executive orders, and moral obligations, the United States owes a singular debt to its Native Americans.

In partial fulfillment of that obligation, in 1976, Congress passed the first Indian Health Care Improvement Act. That 1976 law was the first legislative statement of goals for Federal Indian health care programs. That law established the first statutory requirements for the provision of resources to meet those goals.

In that 1976 act, the Congress found that:

Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

Today, when we get to the bill—I think roughly in about an hour from now—at long last, we will have before us the Indian Health Care Improvement Act of 2007. It has been a long trail that has led us here today. It is important we made the journey to get here. This bill will provide better health care for nearly 2 million American Indians from 562 federally recognized American Indian and Alaska Native tribes. We need to improve the health care of Native Americans. Native Americans suffer from tuberculosis at a rate 7½ times higher than the non-Indian population. The Native American suicide rate is 60 percent higher than in the general population.

Medicare—our program for seniors—spends about $6,800 per person a year. Medicaid—the low-income program for health care—spends about $4,300 per person. The Bureau of Prisons spends about $3,200 per person for health care. But the Bureau of Indian Affairs and the Indian Health Service spends only $2,100 for health care. That is less than a third of Medicare, less than half of Medicaid, and a third less than what the Federal Government spends for medical care for prisoners.

From the beginning of the Indian Health Care Improvement Act of 1976, Medicare and Medicaid have played a part in paying for health care delivered to Native Americans. The 1976 act amended the Social Security Act ''to permit reimbursement by Medicare and Medicaid for covered services provided by the Indian Health Service.'' Today, Medicare, Medicaid, and now the Children's Health Insurance Program are a significant source of funding for health care delivered to Native Americans.

I am proud that an important part of the Indian Health Care Improvement Act before us today is a product of the Finance Committee. That committee's provisions address health care provided to Indians through Medicare, Medicaid, and the Children's Health Insurance Program. Those provisions would increase outreach and enrollment of Indians in Medicaid and the Children's Health Insurance Program. These provisions would protect Indian health care providers from discrimination in payment for services and require States and the Secretary of HHS to consult with Indian health providers, and they would ensure that Medicaid managed care organizations pay Indian health providers appropriately.

It is a good package. It is not near enough. It is an abomination—it is a tragedy what little attention we pay to Native Americans' health care needs. I wish more people in the country would visit Indian reservations. I wish they would visit Indian Health Service hospitals. They would realize the abysmal plight of so many people in America. But this bill helps. It helps provide more resources where people need it—not near enough but more—and I strongly encourage the Senate to pass this bill when we get to it in the next hour or so. Congress should reauthorize the Indian Health Care Improvement Act.

The United States owes a debt to the Native American population whose ancestors are tied up with the very soil all Americans share. The Federal Government owes a duty to help improve the health of American Indians. And we in this Senate have the obligation to pass this act and honor the flesh, the bones, and the blood of our Indian brethren.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

CONCLUSION OF MORNING BUSINESS

Mr. DORGAN. Madam President, what is the order of the Senate?

The PRESIDING OFFICER. Morning business is now closed.

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1200, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1200) to amend the Indian Health Care Improvement Act to revise and extend the act.

Mr. DORGAN. Madam President, this is a piece of legislation we have reported out of the Committee on Indian Affairs in the Senate. Senator MURKOWSKI, the vice chair, and I have worked hard on these issues. We have also made some changes since reporting the bill out of the Committee on Indian Affairs and will offer a substitute that will be cosponsored by both of us. We are now clearing that substitute, and I will, at the appropriate time today, I hope, offer the substitute version.

Some might wonder why there is a separate Indian health care bill, and the answer is relatively simple: because this country has a trust responsibility—a trust responsibility that has grown over a long period of time and has been reaffirmed by the Supreme Court, affirmed by treaties with various Indian tribes—a trust responsibility to provide health care for Native Americans.

The last comprehensive reauthorization of the Indian Health Care Improvement Act was 15 years ago in 1992. The act itself has been expired for the last 7 years, and it is long past the time for this Congress to reauthorize this program. Even though the act has expired, the Indian Health Service continues to provide Indian health care, despite not having a current authorization. But with advances in medicine and in the delivery and in the administration of health care, we need to finally pass this reauthorization and give the Indian population of this country the advantage of the expansions we will do in this reauthorization bill.

This legislation reflects the voices and the visions of Indian Country. It also responds to a number of concerns that have been raised by others, including the administration. The enactment of this reauthorization has been the top priority of myself and the vice chair of the committee, Senator MURKOWSKI. I also wish to say the former vice chair of the committee, the late Senator Craig Thomas from Wyoming, at the start of this Congress, worked very hard on this legislation and cared very deeply about it. We bring this to the floor, remembering the work of Senator Thomas and recognizing his important work.

I wish to describe the need for the legislation as I begin before I describe the legislation itself. I have in the past couple weeks done some listening tours on Indian reservations, particularly in North Dakota, and we heard and saw many examples of deplorable conditions in Indian health care. It is true there are some health care providers in the Indian Health Service that are making very strong efforts to do the best they can, but they are overburdened and understaffed, underfunded. I wish to give some examples of that.

I wish to show a picture—a photograph, rather—of someone I have shown to the Senate before. This is a woman on the reservation in North Dakota, the Three Affiliated Tribes near New Town, ND. Her name is Ardel Hale Baker. Ardel Hale Baker has given me consent to use her image. She had chest pains that wouldn't quit. Her blood pressure was very high. So they went to the Indian health clinic, and she was diagnosed as having a heart attack. The clinic staff determined she needed to be sent immediately to the nearest hospital 80 miles away. She told the staff she didn't want to go in an ambulance because she knew she would end up being billed for the trip, and she didn't have the money. So she

signed a waiver declining the ambulance service, but the Indian Health Service said you have to take it anyway. We have diagnosed a heart attack happening here. You have to take the ambulance.

She arrived at the hospital and Ardel Hale Baker at the hospital was being taken out of the ambulance and transferred to a hospital gurney. As this woman, having a heart attack, was transferred to the hospital gurney, a nurse saw a piece of paper taped to her thigh and the piece of paper taped to her thigh was a piece of paper that was notifying the health care provider there wasn't going to be any money for this patient. The nurse asked this woman who was then having a heart attack what the envelope was. She pulled the envelope that was taped to her leg off her leg and asked: ''Mrs. Baker, is this yours?'' When they looked at the paper, here was the document. The document was from the Department of Health and Human Services, attached by the folks on the Indian reservation, taped to her leg as she left to be put in the ambulance, and it says:

> Understand that Priority 1 care cannot be paid for at this time due to funding issues. A formal denial letter has been issued. If and when funds become available, the health service will do everything possible to pay for Priority 1 care.

What this means is this—contract health care, which cannot be delivered on the reservation. This reservation has a clinic. It is open from 9 until 4 every day, 5 days a week. It is not a hospital, it is a clinic. For health care that cannot be delivered at that clinic, you have to refer the patient somewhere else. But that has to be paid for with contract health care funds, and they run out very quickly.

We had one reservation tell us they were out of health care contract money in January, 4 months into the fiscal year. On this reservation, they say don't get sick after June because the contract health care money is gone. This poor woman was loaded onto a hospital gurney with a piece of paper taped to her leg, saying to the hospital that if you admit her, understand that the Indian Health Service will not pay. This woman must pay. Obviously, this woman had no money. It was a way to say to the hospital that if you admit this patient, you are on your own.

Well, I visited a Sioux reservation at Standing Rock, the McLaughlin Indian Health Center, a couple of weeks ago. The Standing Rock Reservation clinic sees 10 patients in the morning and 10 in the afternoon. I believe they only have a physician assistant there. The reason given in the memorandum about the 10 and 10 was the clinic had only one medical provider and patients signed up in the morning. Anybody arriving after the quotas were made were turned away.

Harriet Archambault received her last prescription for serious hypertension and stomach medication on October 25, 2007. As the medicine ran out, she attempted five times to sign up at the clinic, leaving home early in the morning, driving 18 miles to the clinic but arriving too late each time. Her name was not on the top 10. She couldn't wait at the clinic for a possible opening because she provided day care for three of her grandchildren. So her medication ran out.

In a conversation with her sister prior to her death, she said: What do I have to do, die first before I finally get my medication? She tried five times to drive the nearly 20 miles to the clinic, and five times failed and never got her medicine, and she died a month later, November 27, 2007. Her husband told that story because he wants us to understand that delivery of health care is about life and death.

I have shown a photograph to my colleagues. I wish to do so again. It is a photo of a precious young lady who died, Ta'shon Rain Littlelight. I was at the Crow Indian Reservation in Montana when I met the grandmother of Ta'Shon Rain Littlelight. This was a beautiful 5-year-old girl. She loved to dance. This was traditional dance regalia, and she loved to go to dance contests. Ta'Shon Rain Littlelight died. Here is how she died. Her grandmother and mother and aunt told me she died, with the last 3 months of her life in unmedicated, severe pain. She went back and back and back to the Crow Tribe's Indian Health Service clinic for health problems. They began treating her for depression. Depression. During one of the visits, one of the grandparents of Ta'Shon said: Well, she has a bulbous condition on her fingertips and toes. That suggests there may be a lack of oxygen to the body, or something is going on. Can't you check that? Ta'Shon was treated for depression.

Finally, one day, August 2006, she was rushed from the Crow clinic, where she had gone once again to the St. Vincent Hospital in Billings, MT. The next day she was airlifted to the Denver Children's Hospital and was diagnosed with untreatable, incurable cancer. She lived for 3 more months after the tumor was discovered in what her grandmother said was unmedicated pain. She died in September 2006. Her parents and grandparents asked the question: If Ta'Shon's cancer had been detected sooner, would this child perhaps have lived?

When diagnosed with terminal illness, the one thing Ta'shon Rain Littlelight wanted to do was see Cinderella's castle, so Make-a-Wish sent her to Orlando. But the night before she was to see the castle, in the hotel room in Orlando, she died in her mother's arms.

The question is, for a young girl such as Ta'shon Rain Littlelight, should she have had the same opportunity in health care others have? Is this what we are willing to accept? Not me. This problem has a human face. I could tell a dozen more stories similar to Ardel Hale Baker and Ta'Shon Rain Littlelight.

I sat on Indian reservations for a total of probably 6 hours listening to stories about Indian health care. Let me talk about the statistics, if I might.

For tuberculosis, the mortality rate for American Indians and Alaskan Natives is seven times higher than the American population as a whole.

For alcoholism, the mortality rate is six times higher.

For diabetes, it is not double but triple—three times higher.

Twenty percent of American Indians and Alaskan Natives over age 45 have diabetes. There are reservations in my State where they estimate over 50 percent of the adults have diabetes.

American Indians and Alaskan Natives have higher rates of sudden infant death syndrome than the rest of the Nation.

Injuries are the leading cause of death for Native Americans ages 1 to 44. Injuries include pedestrian accidents, vehicular accidents, and suicides.

The cervical cancer rate for Indians and Alaskan Natives is four times higher than the rest of the population.

The suicide rate for American Indians and Alaska Natives between ages 15 and 34 is triple the national average. For Indian teens in the northern Great Plains, it is 10 times the national average.

I have shown my colleagues a photograph of Avis Little Wind. Avis Little Wind is a young teen who died. Avis Little Wind's relatives gave me permission to use her photograph. This is a 14-year-old girl who lay in bed in a fetal position for 90 days and then killed herself. Her sister had taken her life 2 years previous. Her dad had taken his life. For 90 days, somehow, everybody missed little Avis. The school missed wondering what happened. She lay in bed for 90 days and then took her life because she felt there was no hope and no help.

On that reservation, I went and met with the tribal council, school administrators, and her classmates to try to find out how does a kid, age 14, fall out of everyone's memory and everyone's vision? What I have discovered is there are a lot of issues, but there was not any kind of health care treatment available for a young girl, age 14, who had these kinds of problems. Even had there been health care available, there would not have been a car to drive her there. There is a basic lack of transportation. Aside from the fact they don't have the capability to provide the necessary health care treatment that is necessary to intervene, we have to do better. We have a responsibility to do better.

I wish to address the question of why it is our responsibility. Why is the plight of Native Americans a responsibility to the Federal Government? The simple answer is we are bound to follow the law set forth in the Constitution, in treaties, and in the laws of our land.

We are bound to follow the trust responsibility that has been imposed on us by the Constitution, the rulings of the Supreme Court, and by treaties.

Now, our predecessors long ago negotiated treaties with Indian tribes in which we received, as a Nation, hundreds and hundreds of millions of acres of Indian homeland to help build this great Nation of ours. In return for the enormous cessions of land by the Indians, our country promised certain things. We promised to provide things such as health care, education, and the general welfare of Native Americans.

This chart I am going to show you shows a provision from one of those treaties, and there are a lot of them, most of them broken by our country. This is with the northern Cheyenne and Arapaho. It says:

> The U.S. hereby agrees to furnish annually to the Indians who settle upon the reservation a physician.

It says we have your land and we are going to give you a reservation, but we also understand our responsibility, and we will provide health care. We have failed miserably to hold up our end of the bargain.

This bill doesn't provide health care for Native Americans simply because it is the moral and right thing to do. It is, certainly. It is a bill that requires us to keep our word. It is an active step to fulfill our responsibility, our end of the bargain, struck by our predecessors a long time ago.

In addition to the treaty obligations, the U.S. obligations to Indian tribes are set forth in hundreds of U.S. Supreme Court cases and Federal statutes.

I wish to especially refer to the next chart. In 1831, the U.S. Supreme Court, in an opinion by Chief Justice John Marshall, recognized a general trust relationship between the United States and Indian tribes. He held that the United States assumed a trust responsibility toward the tribes and their members. He explained the United States not only has the authority to deal with Indian tribes and their members, but also the responsibility and obligation to look after their well-being.

In describing Indian tribes as ''domestic dependent nations,'' he also established the relationship in that ruling between the United States and tribes as similar to one between ''a ward to his guardian.''

Now, at the time, these Supreme Court decisions were used by the United States to justify our actions toward the Indians, such as forcing Indians from homelands and placing them on reservations. But we cannot now ignore these court decisions merely because we are doing a poor job of fulfilling our obligation.

At the time of the Supreme Court's decision I described, the United States, through the Department of War, was already providing health care services to Indians on reservations. That practice began in 1803 and the United States has been providing such health care for over 200 years.

One of the initial reasons for providing health care on reservations was because we were the ones who were transmitting diseases to Indian nations and forcing them into environments where diseases would prevail. That became evident in 1912 when then-President Taft sent a special message to Congress summarizing a report that documented the deplorable health care conditions on Indian reservations.

In 1913, the Public Health Service reached a similarly distressing conclusion about the health of Native Americans. The Snyder Act was passed in 1921—I am providing the history so people understand what is the context of health care for Indian nations—one of many laws passed by the Congress over the last 100 years to try to address the health disparities between American Indians and the rest of our society: The Snyder Act of 1921, Indian Health Facilities Act of 1957, Indian Self-Determination of 1975, and the Indian Health Care Improvement Act of 1976 as it was amended in 1992.

President Nixon, in 1970, said in a message to the Congress:

> The special relationship between Indians and the Federal Government is the result of solemn obligations which have been entered into by the United States Government. Down through the years through written treaties . . . our Government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracks of land. . . . In exchange, the Government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans. This goal, of course, has never been achieved.

That is in 1970 from the President of the United States, describing our responsibility.

Let me talk just for a moment about the proposed legislation, having described the reason for us to bring a piece of legislation to the floor of the Senate.

We know—and it has been like pulling teeth to find this out—we know there is full-scale health care rationing on Indian reservations. It should be front-page headline news in all the biggest newspapers in the country, but it is not. If it was happening elsewhere, it would be front-page headlines, but it is not now.

Forty percent of health care needs of Native Americans are not being met. We meet 60 percent of the health care needs; 40 percent are unmet. So it is rationed, and that is why Ardel Hale Baker, having a heart attack, is wheeled in to a hospital with a piece of paper taped to her leg saying: ''This isn't going to be paid for.'' It is health care rationing, there is no other way to describe it, no soft way to put a shine on it. It is health care rationing. It shouldn't happen, and I think it is an outrage, because it is happening on Indian reservations. It is seldom covered by the 24/7 news hour, but it should be, because it is a scandal. I hope this is the first step to begin addressing it.

This legislation will be described by some who come to the floor of the Senate as not enough. I agree with that assessment. This is a first step, at last, at long last, that should have been done a decade ago. It is a first step in the right direction, but it is a first step as a precursor to real reform because we need reform.

This is a reauthorization 10 years after it should have been done. We are reauthorizing and expanding programs that I will describe, but we need to do much more. When we move this legislation through the Senate, through the House, and it is signed by the President, I intend, with the Indian Affairs Committee, to begin immediately with new and more aggressive reforms, and it is urgent we do so.

This bill expands the types of cancer screenings that are available to American Indians. It expands the types of communicable and infectious diseases that health programs can monitor and prevent beyond tuberculosis, which now is the emphasis, to include any disease. It expands the recruitment and scholarship programs and authorizes nurses currently serving in the Indian Health Service to spend time teaching students in nursing programs. These are critical programs, given that there is a 21-percent vacancy rate for physicians in the Indian Health Service, and the entire Nation faces a shortage of nurses.

There is a new program in this legislation dealing with teen suicide on Indian reservations. I held hearings on this subject. We have worked for legislation that will provide screenings and mental health treatment, and we begin to address those issues with this legislation.

Treatment for diabetes: We held a hearing to examine the threat of diabetes to the health of American Indians. It is an unbelievable threat. Diabetes emerges as the most serious and devastating health problems of our time, and nowhere in this country is it worse than on Indian reservations. It affects the Indian population in a dramatic way.

I ask any of my colleagues, if they wonder about that, go to a reservation and see if they have a dialysis unit, and watch the people in the dialysis unit getting dialysis, some having lost limbs, having one leg cut off, another leg cut off, still trying to stay alive. The ravages of diabetes is an unbelievable scourge in Indian country. It is a serious problem for our entire country, but nowhere is it worse than among American Indians. In some communities, the prevalence reaches 60 percent of adults. In the 14-year period from 1990 to 2004, the diabetes rate among Indian kids 15 to 19 years old increased 128 percent.

We expand and enhance the current diabetes screening program. We direct the Secretary to establish an approach to monitor the disease, provide continuing care among Native Americans,

and authorize the Secretary to establish a dialysis program to treat this threatening disease.

Health service to Native American veterans: It is well documented that there is no population in this country that has participated with greater distinction or in greater numbers per capita serving in this Nation's military than Native Americans—none. Many Indians served in World War I even before our Nation recognized Indians as citizens of our country. Think of that, we had American Indians sign up to fight for this country when they were not yet considered citizens of this country.

I was checking recently, and 1962 was the last time when a State finally passed legislation allowing Indians to vote in the State. Think of that, go back to 1961 and understand, there were places in this country where American Indians were not allowed to vote in State elections. And until the early part of the last century, they were not considered citizens. Yet they were signing up to go to war for this country, to fight for this country.

I attended a ceremony on the Spirit Lake Reservation a few months ago and passed out medals—Silver Stars, a lot of medals—to three soldiers who are now elderly men who served this country in the Second World War with unbelievable valor, had fought all around this world for this country and earned these medals—Silver Star, Purple Heart, and various others. They were enormously proud of their country.

Go to a reservation and find out what percent of the population of eligible adults sign up to serve in the military on an Indian reservation and you will be surprised. There is no group of Americans who signs up in bigger numbers to serve this country in the military.

Senator MURKOWSKI and I have a provision in this bill that deals with health services to Native American veterans. More than 44,000 American Indians out of a total Native American population of less than 350,000 at that point served in World War II. Think of that. Out of a population of 350,000, 44,000 of them served in the Second World War.

We had a ceremony in this Capitol Building, honoring the Code Talkers who played a significant role in intercepting and deciphering the codes used by the Nazis. We gave the Congressional Gold Medal to those Native American Code Talkers.

We direct the Secretary of Health and Human Services to provide for the expenses incurred by any eligible Native American veteran who receives any medical service that is authorized by the Department of Veterans Affairs and administered at an Indian Health Service or tribal facility. We want the Indian Health Service to be able to get the funding to provide that health care.

This bill also provides a provision dealing with domestic violence. My colleague, Senator MURKOWSKI from Alaska, was particularly instrumental in this provision. We held a hearing to examine the causes of and solutions to stopping violence against Native American women.

We received testimony that more than one in three American Indian and Alaska Native women will be raped or sexually assaulted during their lifetime. That is pretty unbelievable. We received reports of rapes that were not investigated. We received reports of circumstances where there isn't even the basics, just a rape kit available to take evidence.

We have included in this legislation some approaches that I think will be very helpful: community education programs related to domestic violence and sexual abuse, victim support services and medical treatment, including examinations performed by sexual assault nurse examiners, and a requirement for rape kits. I think we have made significant progress. I thank Senator MURKOWSKI for her special interest in that section of the bill as well.

Finally, we have a section of the bill that deals with convenient care service demonstration projects. The reason for that is I don't want to see the rest of the country move toward convenient care, walk-in clinics with long hours, 7 days a week, only to have Indian reservations be out there with these clinics that serve at times that are not very convenient.

I have a photograph of a clinic I visited last week on the New Town Reservation. They are open, I believe, from 9 a.m. until 4 p.m., 5 days a week. Good for them. They take an hour off for the noon hour, by the way, and close it. I think it is 9 a.m., maybe 8. This is the Minne-Tohe Health Center, of the Three Affiliated Tribes. I visited there within the last week or so. They are open 6 or 8 hours a day, take an hour off for lunch and close it down. If at 5 o'clock in the afternoon, you are having a heart attack there, you are in trouble. If it is Saturday and you have a bone fracture, you are in trouble, because you are 80 miles from the hospital in Minot, ND.

My point is, why not develop a model care system of convenient care clinics open long hours, 7 days a week? Let's extend the opportunity for real health care on Indian reservations.

We have done a lot of other things in this legislation, including establishing the framework for the next approach on reforming this system completely, and that is the establishment of a bipartisan commission on Indian health care which will study the delivery of this system and recommend approaches that we will begin working on immediately in the Indian health care area in our committee.

I have described a number of items that are not positive, and I will later today describe some good news, because there are some positive things going on. One of the Indian reservations I visited in the last week has an Indian health care clinic that is dramatically underfunded. The tribal council voted to take $500,000 of the funds that belong to the tribal government and move it to try to support that clinic. That is good news. Good for them. That takes a lot of courage and commitment.

There are good things happening, and I am going to talk about that a little later today.

The fact is, we have a desperate situation with respect to health care in the Indian nation, and it cannot continue. We cannot allow it to continue. In the name of children who should not have died—Avis Little Wind or Ta'Shon Rain Littlelight or others—we cannot allow this to continue to happen. This country is better than that.

I close by quoting Chief Joseph of the Nez Perce Tribe, located in what is now Idaho. Chief Joseph, one of the great Indian leaders, was pretty upset about a lot of things. Here is what he said about broken promises:

> Good words do not last long unless they amount to something. Words do not pay for my dead people.
>
> Good words cannot give me back my children. Good words will not give my people good health and stop them from dying.
>
> I am tired of talk that comes to nothing. It makes my heart sick when I remember all the good words and all the broken promises.

This legislation on the floor of the Senate is not just some other bill. This is a step toward the completion of promises that have been made, not ''we hope to help you,'' but promises—promises that have been made in treaties, promises that have to be kept as a result of a trust responsibility that exists with American Indians.

To make the case finally, let me say this: There is a chart that shows how much we spend per person on health care, and that chart describes something I think all need to know about the commitment of Congresses and Presidents for a long period of time.

This chart shows we have a responsibility to provide health care for Federal prisoners. We incarcerate them because they committed a crime, and we stick them in prison. But in their prison cell, we have a responsibility for their health care. That is our job, and we meet that responsibility.

We also have a responsibility for health care for American Indians, because of a trust responsibility and because of treaties we signed after we expropriated massive amounts of their land. We don't meet that responsibility. In fact, this chart shows that we spend almost twice as much per person providing health care for incarcerated Federal prisoners as we do providing health care for American Indians. That is why little 5-year-old Ta'Shon Rain Littlelight dies, because she doesn't have the same access to health care that the rest of us do. It is why when a woman goes to the doctor, the doctor shows up at our committee and testifies, saying: You know, a woman came to me who had been to the Indian Health Service doctor. She had a knee

so bad—it was bone on bone—it was unbelievably painful. He said it was the kind of knee that, if it belonged to somebody in my family or yours, we would get knee replacement surgery. We would have to get knee replacement surgery because we wouldn't be able to live with it that way. You can't live with that kind of pain. But she told me she went to Indian Health Service, and they told her to wrap the knee in cabbage leaves for 4 days and it would be okay. Wrap the knee in cabbage leaves. This is a knee which we would get replaced, yet this Indian woman is told to wrap it in cabbage leaves.

Are we meeting our responsibility? People are dying. Forty percent of the health care need is unmet. I have described the conditions that exist in these health clinics and on reservations. The answer is, we are not meeting our responsibility, and at least from my standpoint, and I believe I speak for the vice chair, though she will speak for herself, it is past time, long past the time when this country should keep its promise.

Chief Joseph is long gone, but that doesn't mean we don't have a responsibility to keep our promise to the first Americans. They were here first. To this point, we have had all kinds of circumstances over many years of pushing them to reservations after we took their land, then pushing them off the reservation and saying they had to go to the city. So they got a one-way bus ticket and were told: By the way, we want you to mainstream, to get you off this reservation. So they got a ticket and were sent to the city, and then we decided that was wrong, and we brought them back.

What has been happening in this country in public policy dealing with American Indians is unbelievable, and it has to stop. Let us meet our responsibility, keep our promises, and provide decent health care to the people who were here first. That is what this bill does.

This bill is just a step in the right direction, and it will be followed by significant reform. When we do that, I will feel that, finally, at long last, this country has kept an important promise to those who were here first.

Mr. President, I yield the floor.

Mr. GREGG. Mr. President, I ask unanimous consent to speak briefly at this point. I ask unanimous consent that at the completion of the remarks of the Senator from Alaska I be recognized for up to 10 minutes.

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

The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, I so appreciate the passion and the advocacy of my colleague, the Senator from North Dakota, and working together on the Indian Affairs Committee on an issue in which I think both of us believe very strongly. Both of us believe in the commitment we have to the American Indians and the Alaska Natives, particularly insofar as providing them with a level of access to health care. That commitment is one that in far too many areas we have failed, and that is why it is so important that we are able to advance, as the first legislation of this new year, the Indian Health Care Improvement Act of 2007.

We just celebrated the birthday of Martin Luther King, and as a nation we think about that time in our history when we were not proud of how we treated one another based on color of skin and ethnicity. We know that in many parts of this country, we still have far to go, but we are making progress. Yet, as we look to how the American Indians, the Alaska Natives, and so many in our Native communities have been treated when it comes to the basics in health care, that is an area where I think we need to look very critically and say we can and we must do more.

When I first became the vice chair of this committee, Chairman DORGAN and I sat down, and he said to me: LISA, what are your priorities for the Indian Affairs Committee? What is it that you would like to see advanced? He told me what his priorities were. It is awfully nice being able to walk into that new relationship and agree that the most important thing we could do was to work together in a bipartisan effort to advance legislation that has been working through the process for a number of years, for a number of Congresses, and to successfully move that through the Congress.

We have worked on this bill through three committees of jurisdiction—the Indian Affairs Committee, the Finance Committee, and the HELP Committee—before finally bringing this here to the Senate Floor. I believe this legislation brings new hope for Indian health. It represents a step forward, a step toward the goal of providing our first Americans with health care that is on par with other Americans. It is not the end-all and be-all, but it is a first step, and I am encouraged that we have the opportunity to produce this legislation in support of that goal.

As my colleague has noted, this day has been far too long in coming. Efforts to enact comprehensive reform for the Indian Health Care Improvement Act began in 1999. This act was extended for 1 year back in 2001 through legislation introduced by Senator THUNE when he was a Member of the House of Representatives. Since then, the Indian Affairs Committee has shepherded several reauthorization bills through multiple Congresses, through multiple hearings, through multiple markups, but it has yet to be reauthorized despite the very good efforts of a great many.

This bill would reauthorize and would amend the Indian Health Care Improvement Act and applicable parts of the Indian Self-Determination and Education Assistance Act, as well as the Social Security Act.

The Indian Health Care Improvement Act provides a basic framework for delivery of health care services to American Indians and Alaska Natives. As Senator DORGAN has indicated, this is a Federal responsibility arising from the Constitution, arising from the treaties and from Federal court cases.

The act itself, first enacted back in 1976, was last comprehensively reauthorized in 1992. Think about the status of health care back in 1992 and what has changed. Certainly, in my State of Alaska, we have been able to do so much more in our remote areas because of what we are able to do through Telehealth. Well, back in 1992, I can guarantee you we were not doing then what we are doing now. It is so vitally important that we provide for this authorization to update a system by passing this bill.

We recognize there are still some outstanding issues that need to be resolved. I would like to think they are not central parts to this bill, and I am very confident we can deal with them if our colleagues work with us in the same very bipartisan way that we on the committee have done to advance this.

Now, Chairman DORGAN has given good background in terms of an overview, the need for reauthorization, and he has highlighted it with stories that touch our hearts, as they should. I wish to elaborate a little bit further on the legislation, how it developed, and give that overview as well as some of the key improvements we have in S. 1200.

To really understand the framework of the Indian health care system under this act, you have to keep in mind that there is very significant interplay between this act and the Indian Self-Determination and Education Assistance Act. The Indian Self-Determination and Education Assistance Act provides the process whereby Indian tribes and the tribal organizations contract or compact to take over administration of programs from the Indian Health Service. It is the interplay between these two statutes that provides a great deal of the backdrop for many of the principles that underlie this reauthorization.

The act essentially governs programs for the recruitment and retention of Indian health professionals, for health promotion and disease prevention, for facilities, urban Indians, and a comprehensive behavioral health system. The act also governs important authorizations which increase access to care where there is third-party reimbursement. It also sets forth the administrative organization for the Indian Health Service. Finally, it contains reporting requirements and other regulatory authority for the Secretary of the Department of Health and Human Services.

The bill is intended to improve Indian health care in three areas: First, by increasing access to health care; second, by updating the authorized

services and programs; and third, by facilitating innovative financing systems to help support Indian health.

So let's talk about the increase in access to care. In Alaska, we are talking about access to care all over the State. Geographically, as you know, we are very large, populations are very small, and providers are very limited. And this is throughout all systems, not necessarily just the Indian Health Service. This legislation includes programs to increase outreach and enrollment in Medicare, Medicaid, and SCHIP. We need to have aggressive outreach in order to ensure that the Native people who are eligible for these programs participate in them and so that they can navigate through a relatively challenging enrollment process.

We recognized the critical importance of the Medicare, the Medicaid, and the SCHIP programs for Indian patients. There was an Indian woman by the name of Ski who lives in southwestern Oklahoma. Along with her husband, she takes care of her three grandchildren and her great-granddaughter. About 4 years ago, Ski's doctor, after checking her x rays, found a large spot on her lungs. They also diagnosed her with thyroid cancer. Sadly, though, the IHS Contract Health Service, which is intended to provide for the kind of specialty care Ski needed, notified her that the funds aren't available to pay for it. This is very similar to some of the stories my colleague has mentioned.

Without this additional care, Ski, who is the primary caregiver for her grandchildren and great-grandchild, wondered if she would be around to watch her children and great-grandchild grow up. Fortunately, Ski won't have to face the prospect of living without health care because she did receive it—not through the Contract Health Service but through Medicare. It was these resources which allowed Ski to undergo the biopsy which ruled out lung cancer and to see a pulmonologist and receive testing on a regular basis for the pulmonary fibrosis she was eventually diagnosed to have. She had complete removal of her cancerous thyroid and since that time has been able to receive the follow-up treatments, the testing, and the examinations, all of which we know are very costly but which Medicare helped to cover so that Ski can continue her life raising her family.

She is fortunate and, unfortunately, somewhat of a rarity. Many Indian patients do not have Medicare or Medicaid to help them even though they may be eligible. In the legislation we have, S. 1200, it will help those Indian patients in accessing Medicare, Medicaid, and SCHIP through the outreach and the enrollment programs as well as other means.

Now, accessing third-party reimbursement also helps Indian health providers. The Makah Tribe is a good example of why we should include the provisions to assist tribes in participating in Medicare, Medicaid, and SCHIP. The Makah Tribe is in Washington State, and they are located on a very picturesque 44-square-mile Indian reservation filled with rich forests, wildlife, birds, and plant life—a very beautiful area.

From their home, tribal members can cross the Strait of Juan de Fuca and during the summers go fishing or boating in the Pacific. Although their home is a place of amazing beauty, it is also a very remote part of the State which presents some daunting challenges to the delivery of health services to the tribal members.

It has been reported that the tribe operates a small ambulatory clinic with over 2,000 users and only two doctors. Due to the remoteness of the clinic, the tribe has difficulty recruiting health care professionals, including dentists.

Over 70 miles away you have the nearest town with a full-service hospital, Port Angeles. But those 70 miles can be treacherous to negotiate. It is a winding road, a difficult road. There are several instances when the road has been washed out by storms, leaving no access to or from the reservation.

So there is no surprise that Port Angeles, being a larger town and a more accessible town, has salaries that are more attractive than the reservation.

The Makah Tribe administers the health care services through a self-governance compact for which the tribe should receive contract support costs. However, those contract support costs do not cover all of the indirect costs of health care services. So this impacts the tribe's ability to provide for competitive salaries and to provide for that full array of health care services. But despite all of those challenges, the Makah Tribe has remained resourceful. They are in the process of improving their third-party reimbursements, in particular the Medicare Part B access for eligible people on the reservation.

It is these additional reimbursements that assist the tribe in essentially hedging against the insufficient contract support costs. So when you hear of situations like what we are seeing with the Makah, recognize this legislation will serve to benefit the tribal health providers as well as the Indians who are served by allowing for, again, the additional reimbursement for improving access to care.

The legislation will also improve access by removing barriers to such enrollment such as the waivers of Medicaid copays and allowing the use of tribal enrollment documentation for Medicaid enrollment. These are very important to provisions in this legislation. I hope we will hear more of the good stories, the stories like Ski's, rather than the very damning stories we hear of the system currently.

Now, in updating health care services in Native communities, the bill establishes permanent authority for home and community-based services, and these are services which have been operating in the State of Alaska with very impressive results.

I mentioned just a few minutes ago Alaska's size. Many know Alaska Natives have to travel enormous distances away from their home communities to obtain any level of specialized care. Some people think we make this map up, just to show Alaska's shape over the continental United States—but this is actually true to size—the State of Alaska does stretch from just about Florida into Arizona and beyond, from Canada down to the southern area. Geographically, we are huge.

We have another chart that indicates how the distances for an individual coming from, let's say, Unalaska down here where Arizona is on the map. Unalaska is not only our State's largest fishing port, it is the largest, in terms of volume of fish, fishing community in the United States of America.

For an individual who is coming from Unalaska, which just has a small clinic, to come to Anchorage, which is where all of the points converge in the middle of the map, it is the equivalent of essentially going from Arizona to Kansas for your medical appointment to come to the Alaska Native Medical Center where you can see a specialist.

To give another example, the residents of Barrow, at the northern most part of the State, also have to travel to Anchorage to obtain specialty medical services in the Alaska Native Medical Hospital. That is the distance of coming from the Canadian border down to Kansas for medical services.

If you are coming out of the southeastern part of our State, in many of our island communities, again, you are moving from essentially Alabama or Florida into Kansas. The distances we deal with to provide access to care are realities for us in the State that other people cannot relate to.

We are not talking 100 miles, we are talking several hundred miles. When you put it in context that way, you recognize it is not just the time and the distance traveled, but it is the expense and the distance traveled.

Mr. President, as I was mentioning the distances that we deal with, I mentioned the time to travel, the expense to travel, but think about the situation if perhaps you are elderly, you are ill, or perhaps you do not know what is wrong, and you have to leave your village to go to our cities, our largest cities, which is very intimidating for many of our Alaska Natives in the first place.

They are away from their family, they are away from their community members, they are away from their traditional foods, they are away from their traditional activities. Many of our elders do not speak English, so they are coming into town where the language is different. Think about how well you would heal or how well you would feel in truly a strange and foreign place like this.

Well, the Yukon-Kuskokwim Health Corporation located out in Bethel,

Alaska, in western Alaska, decided this is unacceptable, to have to pull everybody from the villages so far away. And they developed a village and a regional service structure to help the elders, to help the Alaska Native patients with chronic diseases to continue living in their homes or in their community rather than being sent hundreds of miles away to receive special nursing care.

It was their pilot program to take over all home and community-based care in their region, which resulted in a reduction in service waiting time for the disabled and the elders in the region and truly improved the patients' health status level. This legislation may enable other tribal programs around the country to also engage in home and community-based care which would allow Indian patients to remain in their homes rather than face a lengthy hospital stay or nursing home stay in a distant and, again, a strange location.

Our legislation also consolidates and coordinates the various tribal health programs into a more comprehensive approach. As we well know, alcohol and drug abuse among many of our Native communities, and methamphetamine abuse, has reached epidemic proportions in some communities.

We had a gentleman, the former chairman of the Northern Arapahoe, Mr. Richard Brannan. He testified before our joint hearing before the 109th Congress, and then again during the 110th, and told us truly a heart-breaking story of the tragic and painful and terrible unnecessary death of a beautiful little Indian girl at the hands of methamphetamine-addicted individuals.

Chairman Brannan sought our help in providing both prevention and treatment for the drug and alcohol addictions that ravage Native communities. I am pleased that this bill will authorize such assistance and more to help prevent these tragedies from happening to other Indian children.

Now, also during the committee hearing on the methamphetamine plague, we received testimony from tribal leaders about the devastation this terrible drug has brought to their communities. Kathleen Kitcheyan, the former tribal chairwoman of the San Carlos Apache Tribe in Arizona, described a very personal loss, a tragic loss of a grandson to drugs. And she stated that on her reservation, they have methamphetamine users who are as young as 9 years old.

Think about what is happening to our children. Think about drug abuse and the addictions. But to know that children as young as 9 years old are being made the victims, we should all be alarmed when we hear stories like this. And what is equally horrifying are the residual effects of methamphetamine abuse on children. The former chairwoman testified how babies were being born on the reservation, born addicted to methamphetamine, with physical deformities. She stated that on her reservation a 22-year-old methamphetamine user tried to commit suicide by stabbing himself with a 10-inch knife. So many terrible stories. There were 101 suicide attempts on her reservation during the year 2004, 101 attempts that were directly related to meth.

Now, I have described that we are seeing methamphetamine users as young as 9, but it also afflicts the middle-aged as well as the elderly. Once meth has taken hold, few can escape without considerable help. The Indian Health Service estimates it takes well over 60 days in treatment programs in order to overcome these addictions. So just separating a methamphetamine addict from the drug for a period of a few weeks or even a month is not nearly enough to provide effective treatment, not nearly enough to break the addiction. The methamphetamine addicts need the long-term treatment necessary to allow their mental and their physical state to heal and to recover.

For the children, the IHS has 11 federally funded youth regional treatment centers with 300 beds overall. In addition, there are an estimated 47 or perhaps 48 tribal and urban residential programs for adults. One program, the Native American Rehabilitation Association in Portland, OR, which is an urban Indian facility, can also house the patient's family so the patient can also receive the very necessary family support during the recovery.

These programs authorized under the Indian Health Care Improvement Act, and more importantly the Indian and Alaska Natives who are suffering from meth addiction, will benefit from the updates to the behavioral health program in this bill.

Now, we heard from Chairman DORGAN that the Indian health system is funded at approximately 60 percent of the need. And with the new health hazards, whether it is methamphetamine or whatever the hazard is, that face our Native communities, we have to be innovative in finding solutions and resources in building upon the foundations that are set forth in the Indian Health Care Improvement Act.

This legislation will establish the Native American Wellness Foundation, a federally chartered foundation to facilitate mechanisms to support but not supplant the mission of the Indian Health Service. It is modeled after legislation which passed the Senate in the 108th Congress. I am pleased to say we will have an opportunity to advance it in this legislation as well.

I wish to mention two key provisions that have been briefly mentioned. This is regarding the issue of violence against Native women. In the substitute we hope to advance later, we will provide for authorization of prevention and treatment programs for Indian victims and the perpetrators of domestic and sexual violence. We will also provide critical incentives for Indian health providers to obtain certification and training as sexual assault nurse examiners or in other areas to serve victims of violence. Both these provisions build upon very important work this Congress did in the Violence Against Women Act, by addressing some of the systematic shortcomings to improve prosecutions, such as forensic examinations. I will speak on this a bit later.

One of the things we heard in testimony before the committee was that in many of our IHS facilities, they did not have rape kits available. They could not collect the forensic evidence. If you don't have the evidence, you cannot proceed with prosecution. When you hear stories such as this and ask for confirmation that, in fact, this is the situation, that we simply don't have the kits available—it is confirmed—it is no wonder women feel helpless in even seeking assistance after a violent act such as a rape. In addition, simply not having the training for the nurses at the clinics, these are areas of critical shortcomings and ways we can help to make a difference.

There are many good things in this bill, but I do wish to impress upon Members this is truly a national bill. It works to benefit Indians and Indian health programs in communities across the spectrum. I have mentioned that it has been a product that has been in the works for years, a very determined effort on the part of Native health leaders truly from all corners of our Nation. There are over 560 Indian tribes in this country, with 225 of those tribes in Alaska alone. Our Indian tribes and Indian health care system span the Nation from Maine to Florida, California to Washington, and, of course, to Alaska up North. According to recent information from IHS, over 1.6 million American Indians and Alaska Natives receive services in this system at over 600 facilities. These facilities are all over the board, in terms of what they can provide, ranging from inpatient hospitals, general clinics, and health stations.

There are some that look beautiful and there are some that you look at and say: We can do far better.

I mentioned earlier many Natives in the State travel into Anchorage from outlying areas to receive care at the Alaska Native Medical Center. As you can see behind me, it is a large, beautiful facility. It is designed to provide for that advanced level of care and specialty for Alaska Natives from around the entire State. But as one travels away from Anchorage, and you get off the road system out into the bush, the facilities vary in size and certainly in service and are certainly much more modest. We have a picture of the clinic in Atka, AK. It is a little rough around the edges, certainly, but they are able to provide for the basic needs in that region. I checked to identify some of the other challenges the folks in Atka face, in terms of their costs. This is a village where gas is selling for $5.09 a

gallon, and home heating oil is going for $4.99 a gallon.

We have a picture of the clinic at Arctic Village which is located more in the central or interior part of the State. I checked with them this weekend on the price of gas per gallon. It is 7 bucks a gallon. Their home heating oil costs are $6.36 a gallon. So it is expensive to live out there. It is expensive to heat your home. When you are ill or need help, this clinic is where you go in Arctic Village.

We know the need is extensive. The Indian health care system has to provide everything from basic medical to dental to vision services and medical support systems. It has to include the laboratory, nutrition, pharmaceutical, diagnostic imagining, medical records. Obviously, they are not providing that there at Arctic Village.

Senator DORGAN had mentioned the history of the Indian health care system. I will not take the time today to speak to that. I do, before taking a break, wish to take time to talk about some of the updates to the current Indian health care system we have in this legislation. As I mentioned, there have been enormous changes to the medical system since the last reauthorization of the Indian Health Care Act in 1992. So in order to update and provide for an improvement in the overall status of the American Indian and Alaska Native health and well-being, we have to make sure our facilities access is better.

Chairman DORGAN mentioned some of the health statistics and mortality rates we see among American Indians and Alaska Natives. We know these populations are dying at higher rates than others within the U.S. population. On tuberculosis, for American Indians and Alaska Natives the rate is 600 percent higher; alcoholism, 510 percent higher; diabetes, 229 percent higher; unintentional injuries, 152 percent higher; homicides, suicides higher. The statistics are all so troubling as we look to what we are providing and whether we are seeing improvement.

As I say that, we have seen some gains. With passage of the Indian Health Care Improvement Act of 1976, there were some pieces of good news insofar as decreases in mortality rates over the past 35 years. The average death rate from all causes for the American Indian and Alaska Native population dropped 28 percent between 1974 and 2002. We have seen gastrointestinal disease mortality reduced. Even though the death rate for Indians is 600 percent higher than the rest of the United States, we have seen tuberculosis mortality reduced 80 percent, and cervical cancer mortality has been reduced. Infant mortality has been reduced 66 percent. We are seeing good news there. The problem is, we started at such high levels. So, the statistics are still unacceptable.

In addition, we have population growth and economic factors which are creating strong pressure on American Indian and Alaska Native communities and their health care facilities. From 1990 to 2000, the population grew at a rate of 26 percent among the American Indian and Alaska Native populations. Compared to the total U.S. population, it grew by 13 percent. But we know the health care funding for Native people simply has not kept up with the expanding population and inflation.

This effective reduction in health care funding creates our current health status level. We see the survival rate improving, but all we need to do is look at the charts, look at the statistics. We know Indians and Alaska Natives still suffer disproportionately from a number of health problems. We know, for instance, in the area of diabetes, the rates are unacceptably high. While we recognize the Indian Health Service is trying to get this diabetes crisis under control—they are providing diabetes care to greater numbers of Native people than ever before, and we see some success—is it adequate? Is it sufficient?

Another area where we are seeing some success is in the area of vaccinations. We are getting higher vaccination rates for adults over 65. These have been instrumental in helping with some of our health statistics. Screenings, such as for fetal alcohol syndrome, have been helping to reduce the burden of preventable disease.

One of the aspects we face in increasing efficiencies within the delivery of the health care system, we know we have to use new technologies, new techniques, and these are contemplated and outlined in many areas of the legislation before us. I will go back to Alaska as an example of a State that faces very unique challenges in providing for quality health care to the residents in rural Alaska. The majority of the 200 rural Alaska Native villages are not connected to a road system. We don't have the roads. We are 47 out of 50 in ranking of States for the number of road miles, but we rank first out of 50 for overall land mass. We simply don't have a road system to speak of in much of Alaska. When you don't have a road system, you fly. We fly in small bush planes. During the summer months, we rely on skiffs and riverboats to get around. But for the most part, we fly. It is not luxury travel. It is a basic need.

From the chart I have behind me, you can't see the names of all the towns there, but it is there to demonstrate what we deal with as a State. When you look at the IHS budget in Alaska, you may be surprised to see the travel budgets are unusually large, oftentimes larger than staff budgets. That gets people's attention. Are we going out to conferences? No. This is how we get around in the State of Alaska and how we move our patients, those who need to get to that medical specialist. We move them by airplane. Up in the north there you see a community of Barrow. Nuiqsut is a small village outside of Barrow. They have a small clinic. Barrow has a larger one. But in order to receive any level of specialty care, an Alaska Native would have to fly about 700 miles south to Anchorage to the Alaska Native Medical Center. The cost of that particular flight is $1,100 for that person coming out of Nuiqsut.

Over to the west, out on St. Lawrence Island, an individual who is ill in Savoonga and needs to come into Anchorage for medical care is going to pay about $1,000. This is round trip, not that that makes it any better.

Down south of Anchorage, off of Kodiak Island—and if you look at the red lines, it looks as if it must be much closer to Anchorage and therefore less costly—if you are coming from Old Harbor on Kodiak Island, your airfare is going to be about $1,350 round trip to get you to and from.

So when we factor in the budgets of doing business, travel costs are enormous. This is all about access. We also recognize it is not just the cost. Oftentimes during the winter—this time of year—travel is shut down completely. For some of our communities, because of weather conditions, fuel barges have not been able to get into the community, and they have had to fly fuel in to provide for the diesel generation that provides the power in these villages.

Whether it is the ice, the wind, the snow, oftentimes it is just too dangerous to make the trip into town. Blue Cross has estimated that it is 300 times more expensive to operate a hospital or a clinic in Alaska than it is in the continental United States. These are the expenses we deal with.

In the last 10 years, we have seen access to medical specialists and health care improve. Working with my colleague, Senator STEVENS, we have seen a revolution in terms of how health care is delivered to our rural villages with the development of an advanced telehealth network. With 99 percent of the telehealth initiative coming from IHS funding and managed by the Alaska Native Tribal Health Care Consortium, the Alaska Federal Health Care Partnership is a collaboration with the Department of Veterans Affairs, the Department of Defense, and the U.S. Coast Guard. They teamed up together to develop the Alaska Federal Health Care Access Network. They developed a special telehealth cart, and they deploy these carts to small villages in rural Alaska. They are able to provide a very wide variety of clinical services, including cardiology, community health aid training, dental and oral health, dermatology, ear, nose and throat care, as well as emergency room services.

They had a demonstration cart here a couple years back to just kind of show us what it is they were doing. I had just come off a trip up north, and I was due to fly again very soon. My ears were all plugged up. I said: Well, show me how this works. Just standing right there, they put a little monitor in my ear, and they were talking to a doctor in Anchorage. He said: You just have a little inflammation there. You are fine to fly.

What we are able to do with telehealth is to connect many of our Alaska Natives in a very cost-effective way for them to have access to qualified health care specialists without necessarily leaving their village.

We continue to evaluate the cost savings we are seeing as a consequence of this telemedicine. The preliminary data suggests that 37 percent of the time, telemedicine prevented the need for a patient and family escort to travel. That saved an estimated $4.4 million in travel costs. So if you can save $4 million in travel, because we have the technology in front of us, it is a savings for all of us.

Tribal health providers in Alaska with their Federal counterparts have been extremely innovative in addressing the unique health care challenges of our State. The Alaska Federal Health Care Access Network has been working with the IHS service areas to expand quality and affordable health care to American Indians across the United States.

The new opportunities, such as expanded telehealth, found in S. 1200 serve important purposes in promoting good investments. Indian tribes and tribal organizations have performed admirably in developing their health care services and facilities. These types of efforts should be rewarded and encouraged by passage of this bill.

There are some other items I would like to speak to, and I may come back to them at another point in time. But before I conclude for now, I want to mention the importance of the program in the sanitation facilities area.

I could probably stand all day justifying the need for the reauthorization, but one area that has been demonstrated to be one of those very important functions in reducing health disparities is the Sanitation Facilities Program. This program governs the construction, operations, and maintenance of sanitation facilities providing clean water and sanitary disposal systems to Indian and Alaska Native communities.

For us in Alaska, the issue of sanitation is one we have been struggling with for far, far too many years. One in three families—one in three families—in rural Alaska has no sanitation facilities. We are not talking about upgraded sanitation facilities; we are saying no sanitation facilities. What we have in many of our villages, still, unfortunately, is a system we refer to as the honey-bucket system. It is not a very refined system. In fact, it is a system that, for those of us in the State, we look at with shame and say: For Alaska Natives, for Alaskans to have to rely on this as their sanitation system is offensive. It is close to Third World conditions, and here we are in the United States of America, and you have a system where human waste is collected in a bucket and hauled outside and dumped in a collection facility. In some areas, it is less than a collection area; it is dumped in a lagoon. You can walk through some of these communities, and you have waste that is spilled along the wayside.

I have in the Chamber this picture of these two little Native boys. It is like the equivalent of taking out the trash—taking out the honey bucket. If you do not think this does not contribute to some of our health issues in rural Alaska, you have not looked at the facts.

In testimony before the committee, we had Steven Weaver. He is from the Alaska Native Tribal Health Consortium. Steve Weaver has been very instrumental working with us in order to eliminate the honey bucket. But he spoke at that hearing to the challenges families face in communities without sanitation facilities. He said: Other folks in America have the convenience of running water and inside flushing toilets, but in too many of our Native communities we have to haul the clean water into the homes and then haul the honey buckets out of the homes as part of the household chores, part of the daily living.

I was in a community several years back and visited the health clinic there. It was a very small health clinic. It was one of the villages that still do not have running water. There was a honey bucket in the corner of the health clinic. When you think about the need for sanitation, particularly in your clinic, and you realize there is no running water and the human waste must be discarded by walking it out the door, the health consequences in communities without running water, without sewer are very real.

The Alaska Native Tribal Health Consortium reported that infants in communities without adequate sanitation are 11 times more likely to be hospitalized for respiratory infections in comparison to all U.S. infants and 5 times more likely to be hospitalized for skin infections than those in communities with adequate sanitation.

We have about 6,000 homes without potable water, about 18,650 homes that need improvements or upgrades for water, sewer, or solid waste.

This legislation, S. 1200, will maintain the Sanitation Facilities Program. For us in a State such as Alaska, this is vitally important.

Mr. President, at this time I am prepared to defer to Senator GREGG. He has been waiting some time. I do have additional comments I will make throughout the day, but I yield the floor at this time.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that Senator STEVENS be recognized for up to 10 minutes following my remarks.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, is the request for a presentation on the bill without amendment?

Mr. GREGG. Mr. President, I have no knowledge of what the request is other than a request for 10 minutes of remarks.

Mr. DORGAN. Mr. President, I will agree to that request with the understanding it is on the bill without an amendment. I would also like to add to the request that Senator BINGAMAN be recognized to offer an amendment immediately following the presentation by Senator STEVENS.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Without objection, it is so ordered.

The Senator from New Hampshire.

Mr. GREGG. Mr. President, I wish to speak on a subject which is not related to this bill. I congratulate the managers for bringing this bill forward.

STIMULUS PACKAGE

Mr. President, the subject I rise to speak about is one that is fairly topical to today's events, obviously, with what is happening in the international markets and in the stock market and with the Federal Reserve System, and that is the issue of how we as a Congress should proceed relative to what has been called a stimulus or growth proposal.

I want to put down what I would call a red flag of reason, let's call it, as we move forward on this stimulus package. Let's first understand what the problem is we are confronting.

The economy has a serious overextension of credit. This overextension of credit occurred because, as often occurs, there was a period of exuberance in the credit markets.

Now, I have had the good fortune to be involved in Government and in the private sector for a number of years, and I have seen this type of situation arise at least two major times during my career, once when I was Governor of New Hampshire. What happens is people who make loans suddenly find they have a lot of cash available to them to make loans, and they go out and start making loans based on speculation that it can be repaid rather than on the capacity of the individual they are lending the money to to repay it or based on speculation that the collateral for that loan will always maintain its value as originally assessed when, in fact, that collateral may be overstated.

This usually comes at the end of what is known as a business cycle, when basically you have a lot of people out there who probably have not been through a downturn before in their lives who basically put out credit at a rate that is irrationally exuberant—to use the terms of Mr. Greenspan on another subject of the late 1990s bubble—and as a result, credit is put out that, in this instance, was put out at a rate and to individuals who basically did not have the capacity to repay it under the terms of the credit, and with collateral that did not support it.

This exuberant expenditure of credit or promotion of credit was compounded by the fact that we had an inverted pyramid created. That item of credit, that loan that was made, which was

made on collateral which didn't support it and which was made to an individual who probably didn't have the ability to repay it under the terms that it was made on, that item was then sold and it was sold again, and then it was turned into some sort of synthetic instrument which was multiplied and created more sales of the item. So you have basically an inverted pyramid, where that initial loan, which had problems in and of itself on the repayment side and on the collateral side, was compounded by a reselling of the loan over and over again in a variety of different markets and through a number of different instruments, which essentially exaggerated the implications that that loan should not be repaid. So that is what has happened. The loans can't be repaid, in many instances, or the collateral isn't there, in many instances, so these loans start to get called and they start to be foreclosed on. Because they can't be repaid, the lenders find themselves in a situation where they have to obtain liquidity from somewhere else. So they start to contract their lending to basically people who can repay because they must maintain a strong balance sheet, they must maintain their capital reserve, and as a result it feeds on itself and you have a liquidity crisis.

That is a classic business cycle. It is a classic end to a business cycle, and that is what we are in today. It is unfortunate and it causes great personal harm and trauma and it obviously disrupts the economy and people and it affects people's lives. People are damaged by this. Its roots basically go to the fact that there were people lending money to people who should not have been lent money under the terms they were lent it without the collateral they needed for support.

So how do we react to that? How do we keep that from snowballing into a massive slowdown in the economy or a possible potential recession? Well, the discussion is to stimulate the economy through some sort of fiscal policy and the Federal Government taking action—what is known as fiscal policy. There is also, of course, the monetary side. Today the Federal Reserve cut the rates by 75 basis points, and as a result, the market reacted, although it was hugely down when they started. I haven't looked at it recently. I don't know that it reacted in a positive way to that cut in rates.

On the fiscal side, there is a lot of discussion about stimulating the economy. I guess my red flag of reason I am putting out here is, if we are going to stimulate the economy through fiscal policy, let's at least do it correctly. Let's not do it in a way that damages the economy or the future or that basically gets you a short-term political headline but doesn't get you the impact you need, which is to help people through a difficult economic period.

The proposals which are out there, most of which I have seen, have fallen into two categories. One is stimulate the economy by giving people money to spend and the other is to stimulate the economy through energizing small business and large business to invest in economic activity. The problem we have with a stimulative event, which is basically giving people $100, $200, $300, $400, whether you give it to them directly or whether you give it to them through the tax laws, is that money will be spent, but does it stimulate our economy? I am not so sure. So much of the product we buy in America today, that we consume in America today is produced outside the United States: Maybe it stimulates the Chinese economy, but I am not so sure it stimulates our economy. What may be raising the Chinese economy may raise the national economy and that helps us out, but as a practical matter, I am not sure it gets a big bang for the bucks expended, and, most importantly, what happens when you take that sort of action is you borrow this money. This money doesn't appear from nowhere that you are going to put out into the marketplace and say: Here, American citizen, we are going to return you X dollars through a direct payment—probably an inverted tax payment of some sort, for people of low income who aren't basically paying taxes are going to get some sort of payment; middle-income people will get a lesser payment or some marginal payment. That money has to be borrowed. That money gets borrowed from our children. The practical effect of borrowing that money, if it is a $150 billion one-time event, is it compounds because there is interest on top of that and it grows into a lot more money. Then our children and our children's children end up having to pay it back. So do you get the value? Is there a value there that is large enough to justify putting this debt on our children's backs for this type of stimulus event? I think we have to look at that very seriously.

There are proposals out there that we should essentially waive the Social Security payment, for example; that we should say we are not going to require people to make their Social Security withholding payment for 1 month or 2 months or whatever the number would be that we would settle on. That, as a policy matter, has very serious implications for our children and our children's children. Essentially, the Social Security system is supposed to be an insurance system, where you as a working American pay into the system so when you retire, you have paid into the system money which is then returned to you through Social Security payments for your retirement. It is and historically has been viewed as an insurance policy approach, with the Federal Government managing the insurance. Yes, nobody is going to argue the fact that the Social Security system in the outyears does not have the resources to repay the liabilities that are on the books. That is a big issue for us and it is a function of the retirement of the baby boom generation. But you only radically, quite honestly, aggravate that problem by borrowing from the Social Security Administration to essentially fund the short-term fix of a stimulus package.

First, you have created a brandnew event, which has never happened in my knowledge, of taking Social Security dollars and moving them over for the purposes of an expenditure which is a day-to-day operation of Government expenditure. You are basically formally saying the Social Security dollars which are paid in, in taxes, can be used for something other than the purposes of creating obligations which will be paid back in the form of retirement payments. You are saying Social Security dollars will go directly—without any obligation being shown on the Social Security balance sheet—will be taken off the Social Security balance sheet and put directly into the day-to-day operation of Government for the purposes of paying people a stimulus event of $500 or $600. The implications of that are huge, from a public policy standpoint.

We are basically totally readjusting our approach as a nation toward Social Security. You are basically saying Social Security is a dollar in, dollar out purpose, with absolutely no fund and that there is no offsetting balance being set up for Social Security payments, which is used later to pay down the Social Security responsibility. That is a terrible precedent. It may be a theoretical debate, but it is one heck of a big precedent to create that sort of new paradigm relative to Social Security.

Again, what do you get for it? You get a momentary stimulus which may or may not help our economy, because as we all know, most of that consumer event is going to occur with the purchase of products produced outside the country, to a large degree, and you don't get any long-term action which is essentially going to improve the financial viability of the Social Security system. In fact, you significantly aggravate it because, again, you compound that event, and compounding interest has an amazing effect in the area of what will end up as the total cost of that one-time event. Ask the notch babies about that. So this is a policy choice which I think would be truly destructive to the historical role of Social Security in our Government and would be equally probably nonproductive as a stimulus to our economy and probably do more damage than good.

There is also the proposal that we extend unemployment insurance for another 2 weeks, 3 weeks, 4 weeks. Well, that has some arguably positive benefits if you are into a recession, but we are not in a recession. We have essentially what has historically been deemed full employment in this country, which is we are at about 5 percent of unemployment. When you extend unemployment and you have full employment, you are basically creating an atmosphere where people who are on

unemployment have no incentive to go out and find a job, even though there may be a job available because you are at pretty much a full economy. So are you being destructive to the system or are you actually reducing productivity to the system when you make that choice? I would say that is a very debatable issue and one which needs to be looked at before we take this action.

I understand that politically it is a great press release: We are going to extend unemployment for 2 weeks for people who are out of work. Yes, that is a great press release, but if you have earned literally at full employment, which is where we appear to be right now, or pretty close to it, then to extend unemployment at this time could be counterproductive, significantly counterproductive to keeping the economy going, because it would not allow people to go out and find jobs for whom jobs may be available.

Now, if we do move into recession, which is——

The PRESIDING OFFICER. The Senator from New Hampshire has used his allotted 10 minutes.

Mr. GREGG. I ask unanimous consent for an additional 5 minutes.

Mr. DORGAN. Mr. President, Senator STEVENS is to be recognized following Senator GREGG and then Senator BINGAMAN, both of whom I believe are here. Certainly, if the Senator wishes I would not object, but both I think have been waiting for some period of time on the bill.

Mr. GREGG. I appreciate that, and I will try to make this brief and wrap up in less than 5 minutes.

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

Mr. GREGG. So we have that issue, which is fairly significant. The real goal of a stimulus package should be to create an atmosphere where we actually improve the underlying pillars of the economy, and that means we improve productivity, we improve the incentive of people to be productive and go out and create jobs, and that can be done if we need to do this, and that is very much an issue—that can be done through initiatives which are productive, or which are on the productive side of the ledger rather than just on the spending side of the ledger.

I know, historically, people have said: Well, inject money into the economy and that will make it move. That was before we got to an international economy, where essentially injecting money into the economy so consumers can spend money basically moves the Chinese economy, not necessarily ours. What makes much more sense is if we are going to inject money into this economy through some sort of Federal initiative, we should do it in a way where we create economic benefit to our economy, by making it more productive and thus creating more jobs and creating more incentive for entrepreneurs. There are a lot of ways to do that. As we proceed down this road to discuss this issue of stimulus, I will continue to discuss that point and get specific on ways we could do that.

So I wished to raise this sort of red flag of reason before we step on to this slippery slope of a stimulus package which could easily end up being primarily a spending package, for the purposes of addressing whatever anybody happens to deem to be a good political spending issue, that before we step on that slope, we take a hard look at what we will end up with in the way of producing benefit for people today versus producing debt that our children will have to repay and maybe undermining our economy generally for the long term.

I yield the floor at this time.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. STEVENS. Mr. President, I am pleased to speak today in support of my colleague, Senator MURKOWSKI, and explain my strong support for the passage of S. 1200 which will reauthorize the Indian Health Care Improvement Act.

It has been 15 years since the Indian Health Care Act was reauthorized and almost 10 years during which reauthorization bills were introduced in the Congress but received no action. Great advances in the models for the delivery of health care have occurred during this time which need to be incorporated into the Indian health care system. This bill does that. The health needs of Alaska Natives in our State and American Indians throughout the country continue to grow. It is important we pass this bill.

Ten years ago, we opened the Alaska Native Medical Center in Anchorage. It is the only tertiary care hospital in the Indian health care system. At the same time, we created the Alaska Native Tribal Health Consortium, and Alaska Natives took over the management of the entire Native health care system in our State.

I believe much has been done in the last decade. Alaska now has the best health care system in the entire country. The reason, in my judgment, is that the system is operated by the Alaska Native people, who have shaped it to fit their own needs. But Alaska Native health leaders across our State have told me again and again that they believe this legislation needs to be passed because it contains new provisions to aid delivery of health care to the Indian people. It is necessary to continue their critically important work.

This Indian Health Care Improvement Act is a comprehensive bill. Every aspect of what it takes to improve a true system of care to the Alaska Natives and the American Indians is in this bill.

The health status of Alaska Natives and American Indians is poorer than that of the average American. It is poorer than what the average American receives. Many of our people live in remote communities with little economic base, high unemployment rates, and low income levels. These conditions create a ''perfect storm'' of health care obstacles for Alaska Native people. These people must travel farther than others throughout our country to receive health care services. They are less healthy than the average American, and they have more medical issues they face because of the circumstances under which they live.

In Alaska, many communities are not served by roads. For instance, a pregnant woman living in Adak, way out on the Aleutian chain—almost 1,200 miles from Anchorage—must travel by air to deliver her child. She must fly to Anchorage to do that. As she does, she will have flown more than 5 hours, and she will be flying on a plane that is only available 2 to 3 days a week. As it is almost everywhere in Alaska, the weather conditions are really great problems and can delay the start of such a trip for a week or more. Of course, all of these concepts increase the cost of health care, but it is the availability of health care that counts, and it is really difficult for our people to get to the areas where health care can be provided to them.

The Alaska Native Tribal Health Consortium and the Native health organizations in our State have worked hard to improve the health status of our Native people. Rates for diseases, such as tuberculosis, have dropped dramatically, and we have improved access to health care and basic public health measures, such as childhood vaccinations, and installation of water and sewer systems in rural Alaska has also improved our health care. Between 1950 and 2007, Alaska Native life expectancy rose from 46 years to 64 years of age. Those are improvements brought about by health care.

However, in Alaska, as in other parts of the country with Indian populations, many infectious diseases have increased, and other health problems have taken the place of those we have eliminated. Respiratory illness outbreaks threaten the lives of Native babies and toddlers and fill our hospital beds in the Yukon-Kuskokwim area of our State every winter. Noninfectious conditions, such as suicide, violent injury, and intentional injury, still plague Alaska Natives at a very high rate. As the population ages, rates of cancer, heart disease, and diabetes threaten the gains we have made in life expectancy.

The Alaska Native health system has been innovative and pioneered access to and delivery of health services to the Native people in Alaska. Yet huge disparities continue to exist. This bill needs to be passed and funding increased to address these health disparities to save and improve lives in Alaska and to reduce the cost of health care throughout our area and Indian Country.

Title I of this Indian health care bill provides support for Native people to receive training as health workers. Each year, Alaska Natives and American Indians complete their education,

supported in part by programs authorized under title I, and return back to their home to take positions as nurses, doctors, social workers, behavioral health specialists, and administrators—all to improve the health care system.

The Alaska Community Health Aide Program, which is an important example, is an outstanding example of innovation in the delivery of health care in remote communities.

When I came to the Senate, there was hardly any health care in our Alaska villages. They received their health care by the wife or a spouse of the superintendent of the Indian school or native school, calling in to Anchorage, their one central hospital. There were no health aides. We created and pioneered the concept of community health aides.

Through the many years since that time, Alaska Native health leaders worked with the Indian Health Service to train community members to provide tuberculosis treatment during epidemics in Alaska, and the program has provided more than 500 community health aides, with all levels of health care in over 178 remote villages where there is no other type of health care provider.

Recently, the Community Health Aide Program was expanded by the Alaska Native health system, making specifically trained behavioral and dental health aides available to people living in villages. Today, Alaska's telemedicine system, with installations in 235 sites across Alaska, allows the community health aides to have direct access to physicians and dentists in regional hub hospitals in Anchorage and Fairbanks. They can use telemedicine to contact outside specialists who can assist them in the various clinics throughout the country. I will speak of a few of these people.

Jennifer Kalmakof, a community health aide from Chignik Lake, is an example of how important the aides are in their communities. Jennifer won the 2007 Vaccine Alaska Coalition's Excellence in Immunization Award, presented to her at the Alaska Public Health Summit this past December. She made it her mission to increase and improve and maintain immunizations at the local level. She started her own system to keep track of infants, children, elders, and adults, using her own money to buy tackle boxes in which she organized clinic vaccines and kept them in her own refrigerator. She pioneered keeping track of the type of assistance these people need in terms of immunizations and various types of vaccinations.

Title II of the bill addresses the range of services authorized, recognizing the change which has already occurred in our non-Native health system, where the emphasis has shifted from health care to home- and community-based care—such as provided by the young woman I mentioned—especially for long-term care services. All Alaska Natives need to have access to these home-based services, and the assisted living and nursing homes that recognize the cultural needs of Alaska Native elders need to also be available.

Title III of the bill addresses safe water and sanitation needs. There continues to be enormous unmet needs for investment in safe water and sanitation systems in Alaska Native communities. Currently, 26 percent of rural Alaska Native homes lack adequate water and wastewater facilities.

For instance, Andrew Dock lives with his large family in Kipnuk, AK. In his household, there are two adults, six boys, and three girls. The youngest child is 1, and the oldest is 22. There is no piped-in water in this village and not even a central watering point. In the winter, water is obtained by chopping ice from tundra ponds with a steel ice pick and hauling it to his home in three 30-gallon gray garbage cans in a sled pulled by a snow machine. In the summer, he obtains water by collecting rainwater from domestic rooftops. It is also possible to haul water from a lake at Tern Mountain, which is a 13-mile boat trip. Hauling water is a daily chore—one to three trips a day to support drinking, cooking, and washing clothes. He hauls over 1,000 gallons of water per week to just keep safe water for the Dock household.

In Kipnuk, sanitation is accomplished by 5-gallon honey buckets in each home. I know Senator MURKOWSKI talked about this. Buckets are self-hauled twice a day through the living space of the family and deposited in a collection hopper nearby. Buckets must be emptied into another bucket when they become too full to carry without spilling in the home.

Collection of the hoppers is often delayed, and there can be as many as five buckets waiting next to the hopper to be emptied.

More than 6,000 homes in rural Alaska are without safe drinking water, and nearly 14,000 homes require upgrades or improvements to their water, sewer, or solid waste systems to meet minimum sanitation standards.

There is also an immense unmet need for health care facilities throughout the Indian Health Care system, including in remote parts of Alaska. In Barrow, the northernmost point in the United States, $143 million is needed to build the only hospital in an area the size of Idaho. And in Nome, $148.5 million is needed to build the only hospital in an area the size of Virginia.

Other parts of the bill address the ability of native health organizations to bill third parties for health care services delivered to native beneficiaries also covered under public or private insurance programs. These funds provide critical additional funds to make up for shortfalls in Indian Health Service funding, including for emergency care.

While the typical emergency response time from emergency 911 call to hospital care is generally clocked in minutes, in Alaska it is clocked in hours. In 2005, a young man in Bethel, Alaska, was stabbed in the stomach during an early morning fight and needed to be air-ambulanced to Anchorage, more than an hour away by jet. Due to weather and mechanical issues, the patient finally arrived at the hospital in anchorage about 7 hours after the first emergency call. A one-way air ambulance flight from Bethel to Anchorage costs more than $13,000.

Finally, the bill addresses behavioral health needs of native people. The life expectancy of people with mental health issues is 25 years less than those without mental health issues. In Alaska that means that while we continue to make strides towards improving life span, we have not yet been able to adequately address this issue due to program and funding limitations.

The combination of substance abuse and mental illness is associated with much higher rates of multiple diseases and early death. One in eleven Alaska native deaths is alcohol-induced, and alcohol was the fourth leading cause of death from 1993 to 2002 in Alaska. Alcohol contributed to 85 percent of reported domestic violence cases and 80% of reported sexual assault cases between 2000 and 2003. Suicide among Alaska natives remained steadily at two times the non-native rate in Alaska from 1992 to 2000.

Integrated behavioral health programs can make a difference in this picture. Maniilaq, the native health organization in northwest Alaska, operates a very successful behavioral health program called the Mapsivik Treatment Camp, which provides alcohol treatment for families in a remote location. It is a year-round program that integrates the family into cultural and behavioral health treatment models. The camp has been successful in reducing recidivism and helping to heal whole families. And the Raven's Way program operated by the Southeast Alaska Regional Health Consortium for adolescents has now graduated more than 1,000 kids. Many of these graduates have gone on to lead healthier lives, become hardworking adults, and some have even become native leaders.

In conclusion, the need to pass this legislation now is clear, and I urge my colleagues to support passage of the bill.

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

Mr. BINGAMAN. Mr. President, the Indian Health Care Improvement Act was first enacted in 1976. It has enabled us to develop programs and facilities and services that are models of health care delivery with community participation and with cultural relevance.

We have accomplished a substantial amount under the Indian Health Care Improvement Act. American Indians and Alaska Natives today have lower mortality rates from diseases, such as heart disease and cerebrovascular disease, malignancy, and HIV infection,

than they did before. Under the Indian Health Care Improvement Act, the infant mortality rate has decreased since 1976 from 22 per 1,000 to 8 per 1,000.

In spite of the notable improvements, there are still shocking health disparities that remain for Indian people. Let me give you some examples from my home State of New Mexico.

First, let me say that over 10 percent of our population in New Mexico is American Indians. We have the second highest percentage of Native Americans of any State in the country.

Native American women in New Mexico are three times as likely to receive late or no prenatal care compared to national rates. Native American New Mexicans are more than three times more likely to die from diabetes compared to other New Mexicans. Death rates for Native American New Mexicans from motor vehicle crashes are more than double those of non-Indians. That is largely explained because American Indians on tribal lands have accidents that are far from trauma centers, and therefore they do not have rapid access to lifesaving care.

These disparities in mortality rates contribute to a shortened life expectancy for Indians compared to other Americans. National statistics show that Indians live, on average, 6 years less than do other Americans. That discrepancy is as high as 11 years for some South Dakota tribes.

The Indian Health Service is one of the primary sources of health care for Native Americans. For years, the Indian Health Service has struggled to meet the needs of the Indian population, but in doing so they have faced enormous challenges. There are aging facilities, staff shortages, funding shortfalls, and all of these present challenges to the Indian Health Service. When facilities and staff are not sufficient to meet the needs, contract health services need to be purchased at the prevailing rates. Funds supporting contract health services generally run out by about midyear, and that leaves the Indian Health Service with no alternative but to ration care. Life-and-limb saving measures are selected by necessity over such things as health promotion and disease prevention.

So what resources would be adequate to meet these challenges? To answer that question, I call my colleagues' attention to information that has been provided by the Congressional Research Service.

Let me put up a chart that makes the comparison that I think is useful. This is a graphic illustration of 10 years of health care expenditures per person in various of the programs we support. The top line, the red line, is Medicare, primarily individuals 65 or older in this country. Medicaid is the level of funding per capita we provide under Medicaid. The Indian Health Service number is this blue line which is the lowest line on the chart. The sum of all public and private sources of health care dollars divided by the number of users nationally, or the average health care expenditure per American, is depicted in the green line. So we can see that the average American gets substantially more per recipient spent on them for health care services than does the average Indian American.

In 2004, the U.S. Commission on Civil Rights produced a report entitled ''Broken Promises: Evaluating the Native American Health Care System.'' This report contained four important findings.

No. 1, they found annual per capita health expenditures for Native Americans are far less than the amount spent on other Americans under mainstream health plans. That is exactly what this chart says.

No. 2, they find annual per capita expenditures fall below the level provided for every other Federal medical program. And, again, that is demonstrated very well on this chart.

No. 3, they found annual increases in Indian Health Service funding have failed to account for medical inflation rates or for increases in Indian population.

And, No. 4, they found that annual increases in Indian health care funding are less than those for other health and human services components.

This 2004 report concluded:

> Congress failed to provide the resources necessary to create and maintain an effective health care system for Native Americans. The Indian Health Care Improvement Act has not been reauthorized since.

That report was done in 2004. Reauthorization of this legislation is long overdue. As many of my colleagues have already said, we need to act now to ensure its swift passage because of the very serious funding shortages within the Indian Health Service.

Senator THUNE and I are offering an amendment to provide for an expansion of section 506 of the Medicare Modernization Act, which protects Indian Health Service contract health services funding. This contract health services funding is utilized by the Indian Health Service and tribes to purchase health care services that are not available through the IHS and tribal facilities. These are health services such as critical medical care and speciality inpatient and outpatient services.

Nationally, the Indian Health Service and tribes contract with more than 2,000 private providers in order to get these services. Unfortunately, because of the very low funding levels available for contract health services, funding often runs out in midyear, as I indicated before.

Making this problem even worse, prior to section 506 of the Medicare Modernization Act, there was no limitation on the price that could be charged for contract health services. In many instances, providers were charged commercial rates or even higher rates for those services, far in excess of the rates that were being paid by Medicare, by Medicaid, by the Veterans' Administration, and by other Federal health care programs.

Section 506 of the Medicare Modernization Act provided that Medicare participating hospitals had to agree to accept contract health services patients and had to agree that Medicare payment rates would serve as a ceiling for contract health services payment rates to those hospitals.

AMENDMENT NO. 3894

Mr. President, I send a Bingaman-Thune amendment to the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], for himself and Mr. THUNE, proposes an amendment numbered 3894.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to provide for a limitation on the charges for contract health services provided to Indians by Medicare providers)

At the end of title II, add the following:

SEC. _____. LIMITATION ON CHARGES FOR CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PROVIDERS.

(a) ALL PROVIDERS OF SERVICES.—

(1) IN GENERAL.—Section 1866(a)(1)(U) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(U)) is amended by striking ''in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title,'' in the matter preceding clause (i).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to Medicare participation agreements in effect (or entered into) on or after the date that is 1 year after the date of enactment of this Act.

(b) ALL SUPPLIERS.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) LIMITATION ON CHARGES FOR CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY SUPPLIERS.—No payment may be made under this title for an item or service furnished by a supplier (as defined in section 1861(d)) unless the supplier agrees (pursuant to a process established by the Secretary) to be a participating provider of medical care both—

''(1) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian Tribe, or Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

''(2) under any program funded by the Indian Health Service and operated by an urban Indian Organization with respect to the purchase of items and services for an eligible Urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding payment methodology and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after the date

that is 1 year after the date of enactment of this Act.

Mr. BINGAMAN. Mr. President, the Bingaman-Thune amendment would build on section 506 to ensure that these requirements, the requirements that 506 apply to hospitals that were contracted with by the IHS, apply not just to hospitals but to all participating Medicare providers and suppliers. In other words, the amendment would ensure that scarce contract health services dollars are used more efficiently, providers would be ensured a greater likelihood of receiving contract health services payments and would be provided continuity in the payment levels with other Federal programs.

The Bingaman-Thune amendment is supported by a wide range of Indian health advocates, including the National Indian Health Board, the Navajo Nation, and First Nations Community Health Source in New Mexico.

I urge my fellow Senators to join Senator THUNE and myself in supporting this important amendment.

In conclusion, I underscore that passage of this overall legislation, the Indian Health Care Improvement Act, is critically needed and long overdue. I congratulate the Senator from North Dakota for his persistence in getting this legislation brought to the floor, and I congratulate and thank our majority leader, Senator REID, for scheduling this as the first item of business in this second session of this Congress. It speaks volumes about the importance Senator REID attaches to this legislation.

I hope my fellow Senators will join me in strongly supporting passage of the legislation once the Bingaman-Thune amendment has been adopted.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. CARPER). The Senator from North Dakota.

Mr. DORGAN. Mr. President, I thank the Senator from New Mexico for offering the amendment. I know he offers it on behalf of himself and Senator THUNE from South Dakota. I fully support the amendment. This amendment will provide maximum opportunity to stretch the Indian health care dollars. The amendment is a thoughtful amendment that will, in my judgment, strengthen the underlying bill.

I am very interested in supporting it. We are working to see if we can get a vote on this amendment today. I believe the majority leader wishes to begin voting today, and I hope perhaps we can arrange consent to have a vote on this amendment later this afternoon.

I also thank the majority leader for bringing this bill to the floor of the Senate. When I was vice chairman of the Indian Affairs Committee and Senator JOHN MCCAIN was chairman, we worked on this bill. We tried very hard to get it to the floor, but we were not successful. This is the culmination of lot of work and important work, in my judgment, to get it to the floor. I appreciate the cooperation of the majority leader for giving us the opportunity to get it to the floor.

My hope is we will have the cooperation of other Members of the Senate. If there are amendments to be offered, we wish they would come and offer those amendments. We would like to get amendments and time agreements and try to find a way to complete this legislation.

I also failed to mention earlier that the Senate Finance Committee had a referral on this bill. They did some very important work. Senator BAUCUS, Senator GRASSLEY, and other members of the Senate Finance Committee were very helpful, as has been Senator KENNEDY and Senator ENZI on the HELP Committee, and Senator KYL and others.

This bill is bipartisan. We are trying very hard to get this legislation completed. As I indicated earlier, this is long past the time when this should have been done. People are literally dying for lack of decent health care that most of us take for granted, most of us expect and receive. That is not the case with respect to Native Americans. We desperately need to change this situation.

My hope is, if there are those who are intending to offer amendments today, that they come to the floor and offer the amendments. We know of a number of amendments. I appreciate the cooperation of Senator BINGAMAN in offering his amendment now. If there are others, I hope we can proceed.

Mr. President, I wish to briefly speak about another issue we have been dealing with. My colleague from New Hampshire spoke briefly, and I think in the absence of others being in the Chamber, I wish to speak as in morning business for 5 minutes.

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

THE ECONOMY

Mr. DORGAN. Mr. President, some of my colleagues have spoken today about the difficulty in the economy. I am concerned about it, as are virtually all Americans at this point. The stock market seems to be bouncing around like a yo-yo. The economy is slowing and consumer spending is down. Recently, there was a substantial increase in unemployment in a single month—and a whole series of items that suggest there are real economic problems.

My colleague from New Hampshire said: I am concerned about a stimulus package. So am I, but in my judgment, we need to err on the side of taking action rather than err on the side of doing nothing. The Federal Reserve Board this morning cut interest rates by 75 basis points. That is a blunt instrument of monetary policy to try to address what is seen as a serious weakness in this economy.

I want to say this: No matter what we do—and we almost certainly will produce some sort of stimulus package—I believe a stimulus package should provide some tax rebates to middle and lower income people. It also ought to provide an extension of unemployment benefits. We have done that during previous economic downturns. I think a stimulus package should provide investment tax credits for businesses with an end date and other temporary tax incentives to persuade businesses to make capital investments now when the economy would benefit most from it. So we should do two things: We should put money in the hands of consumers, middle to lower income consumers, and we also should stimulate businesses to make needed capital investments earlier rather than later in order to prime the pump with respect to the economy.

I also think it is important to consider, even as we talk about stimulus, making investments in this country's infrastructure. There is nothing that puts people back to work more quickly than money that goes to building roads and bridges and making other improvements in this country's infrastructure that are so desperately needed. Many of us are working on and talking about that issue. But that ought to be a part of a second phase of a stimulus package. To ignore that, in my judgment, is to ignore significant job-creating opportunities at a time when we desperately need those opportunities.

Having said all of that, I believe we need to act to provide confidence to the American people about the future—after all, that is what the business cycle is about. If people are confident about the future, they manifest that confidence. They take the trip they wanted to take. They buy the car they wanted to buy. They do the things that manifest confidence in the future. That represents expansion.

If they feel as if the future has some troublesome aspects, they say: I am going to defer taking the trip, I am going to defer buying that car or piece of equipment, I am going to defer purchasing that piece of furniture, and then the economy contracts.

There are some in Washington with an overinflated sense of self who think this is a ship of state with an engine room. And you get out of the engine room and you dial the knobs and the switches and the levers—M–1 B, taxes and all of these things—and somehow the ship of state just sails right on forward.

That is not the case at all. This ship of state moves or fails to move based on the people's expectation about the future. If they are optimistic, they do things that express that optimism, and the economy expands.

I wish to talk for a moment about some of the fundamentals. We can genuflect here and even do some dancing in the Senate Chamber about the issue of stimulus packages, but if we don't address the fundamentals, we are not going to get out of this problem.

Every single day, 7 days a week, all year long, we import $2 billion more in goods than we export. So we run up a

bill of $700 billion plus a year in trade deficits. Our trade situation is an abysmal failure. Do you think the rest of the country doesn't know that? Do you think that has no impact on the falling dollar? Of course it does. It is one of the reasons the dollar is falling.

In addition to that, we have a fiscal policy that has been reckless. Last year, we had a $196 billion request from the President in front of us, none of it paid for—add it to the debt, he says—for Iraq and Afghanistan and restoring military accounts. Well, that is $16 billion a month, $4 billion a week, and none of it paid for. That is on top of the yearly deficit, which is understated. It uses all the Social Security money as if it were other revenue in order to show a lower deficit.

The American people know better and so do the financial markets. They see the combination of a reckless fiscal policy and a trade policy that is deeply in debt. They see a country whose fundamentals are out of line. These electronic herds, called the currency buyers or currency traders, when they see these things and they run against the currency, a country is in trouble. We have to get our fundamentals in order. We need to fix our trade policy, stop these hemorrhaging deficits, and we need to fix our fiscal policy.

We can't say yes to a President who says let's fight a war and do tax cuts for wealthy Americans at the same time. Let's fight a war, spend a lot of money doing it—two-thirds of a trillion at this point but heading north—and none of it paid for; all of it borrowed. This from a conservative President. This Congress has to stop saying yes to that. This reckless fiscal policy has helped set the stage and table for part of what we have seen the last couple of weeks, the jitters and concerns about where this country is headed and the economic difficulty we are now in.

Let me talk about something my colleague from New Hampshire talked about, and that is the underlying issue of the so-called subprime loan scandal. That is a fascinating thing. Someday somebody will do a book about that and just about that issue. Here is what happened, and we know better. Everybody knows better.

You wake up in the morning and go to brush your teeth and perhaps you have a television set on. You are sort of getting ready for work and you see a television ad. We see them every morning, and the ads say: Do you have bad credit? Do you have trouble getting a loan? Have you been missing payments on your home loan? Have you filed for bankruptcy? It doesn't matter. Come to us; we will give you a loan.

We have all seen these ads, and you think to yourself: Well, how can they do that? How can they advertise that if you have bad credit you can borrow money from them? The fact is, you can't do that. But that is what we were doing all across this country. Here is what was happening. Mortgage brokers were making a fortune in big fees by selling subprime mortgages. The companies that were writing these mortgages, the largest of which was Countrywide Financial, were saying to people: You know what, take our low-interest mortgage, with a teaser rate at 2 percent. It won't reset for 3 years. By the way, if you have an existing home loan, so you can get rid of that and we will lend you money you can pay back at a 2-percent interest rate, and it will not reset for 3 years, during which time the market is going to go up and you can flip it and sell it. In any event, what we will do is decide that on your home loan you don't have to make any principal payments at this point, just interest. We will add the principal later on.

Or they will say, borrow this money from us, and we will make the first 12 months' payments. For the first year, you make no payments at all.

OK, that practice was totally, completely and thoroughly irresponsible by a bunch of greedy folks. They are talking to people, cold-calling them and saying, we would like to put you in a better mortgage but not telling them, of course, there is a prepayment penalty. They are telling you monthly mortgage payments that didn't include real estate taxes, insurance costs, and so forth. So they were quoting borrowers 2 percent teaser rates with prepayment penalties that didn't include the escrow. So they put these people in these loans.

Now, were the victims partly at fault? Sure. By victims, I am talking about those who took these loans out. But these were high-powered salespeople working for big companies that were putting bad products in the hands of a lot of unsuspecting people.

Then what do they do? They have these subprime loans packaged up with other loans. It is sort of like the old days when they used to put sawdust in sausage in the meat plants and mix it all up as filler. Then they would cut it up and you would never know where the filler was and where the sausage was. Well, similar to that, they would take the good loans and the subprime loans and they would mix them all together and put them in securities—securitize them. Then they would sell the securities to these hedge funds, among others. So hedge funds were buying securities. They didn't have the foggiest idea what they were buying because the rating agency said it looked okay. These agencies were dead from the neck up.

Everybody was greedy, and now the whole tent comes collapsing down. Now, you say, how could that be? Well, it was because people were loaning money to people who were never going to be able to repay it. The CEO of Countrywide, the largest company doing this, made hundreds of millions of dollars selling the stock back. It looks like Countrywide is going to go belly up, so Bank of America comes in and buys Countrywide. No idea why, but the big guys, they all waltz off smiling ear to ear, sparkling teeth and big smiles. Why? Because they made a lot of money—hundreds of millions of dollars. Meanwhile, all these folks can't repay their mortgages and are left to try to pick up the pieces and then we wonder what on Earth happened here.

In the midst of all this, this morning I was listening to a TV show with a man named Jim Cramer, who talks about stock prices. He has a TV show. Half the time he is yelling. I don't have the foggiest idea why he thinks that is the approach to use to thoughtfully talk about stock prices, but apparently it is successful. So he says this morning that one of the ways we should deal with the problem in the economy is to start trying to provide some recompense or some money to the insurers of bonds and other things that are going to get hit—derivatives, he said. And I thought, I understand that language. He is talking about credit default swaps.

That sounds like a flatout foreign language, but it can't be because I don't speak a foreign language. Credit default swaps. So what Jim Cramer was talking about on the television this morning is that in order to bail out this country, his approach is we ought to provide about 50 percent of taxpayer money to the losses for those who have credit default swaps. Let me talk a moment about what this means because, as I said, it sounds completely foreign.

Hedge funds in this country are largely unregulated. I, Senator FEINSTEIN, and many others have tried for a long time to say that is dangerous for this country. Hedge funds are somewhere around $1 to $1.5 trillion. Now, that is not so much, considering mutual funds are about $9 trillion. The total of the stocks and bonds in the stock market and bond funds are about $40 billion. So hedge funds are about $1 to $1.5 trillion. But hedge funds represent one-half of all the trades on the stock market. Think of that—$1 trillion plus unregulated—and they comprise half the trades on the stock market.

Now, because of the very heavy use of the leverage, it is a fact that hedge funds can lose much more than they are worth. If somebody goes into a casino in Las Vegas with a pocketful of money and grinning, thinking they are going to win a lot of money but end up losing it all, in most cases the only thing they lose is the money they have. That is not the case with heavily leveraged hedge funds.

That is why the episode with Long-Term Capital Management, a hedge fund that had the smartest people working for them, was so important that over a decade ago the Federal Reserve Board had to try to save Long-Term Capital Management. That hedge fund was unbelievably leveraged, over $1 trillion. Its collapse would have affected the entire American economy.

So here is what we have. We have this language now called credit default

swaps. The credit default swap is a derivative, and it is an insurance policy on a bond or some other instrument. The person who sells the swap is actually writing a policy that collects a premium, and it says if nothing goes wrong with the underlying instrument, the person who sold the swap gets the premium and looks like a genius. If, however, the bond or the underlying instrument collapses, then the swap seller has to make good. The notional amount—understand this—the notional amount, the aggregate of bonds, loans, and other debt called by credit default swaps in the United States, is now $26 trillion.

I have spoken before on the floor of the Senate about creating a house of cards, every child has done it, and then pulled out a card on the bottom. Everyone understands what happens to the house of cards. We now have roughly $1-$1.5 trillion in hedge funds, as I understand it, doing one-half of the stock trades on the stock exchanges. In most cases, hedge funds have a notional value of $26 trillion in credit default swaps, and the question is: Where is all this exposure? How much exposure? We don't know. Most hedge funds are unregulated, and a whole lot of folks in this Chamber have wanted to keep it that way, despite the efforts of some of us who believe it is dangerous to our economy to pretend this kind of risk does not exist.

It is interesting to me that we are in this situation and troubling to me we are in a situation that all of us knew was going to be difficult. You can't run a $2-billion-a-day trade deficit without consequence. Warren Buffett always pointed out with the housing bubble that every bubble bursts. It is one of the immutable laws. The question isn't whether, it is when. He makes the same point about the trade deficit. The trade deficit is unsustainable. The question isn't whether we will see consequences, the question is when will those consequences exist.

The consequences are beginning to exist now, with the declining value of the dollar and the combination of all the other issues—the highest deficits in human history, the trade deficit, a fiscal policy that is completely and thoroughly reckless, combined with the scandal that exists with respect to subprime loans and the massive amount of unregulated hedge fund credit swap defaults. I mean it is staggering to see what we have done. Again, the credit default swap is a notional derivative whose value is dramatic and the consequences of which could be dramatic for the entire economy.

Most regulators were looking the other way and doing so deliberately. If ever one wonders whether thoughtful and effective regulation is necessary, look at all this. If anyone has ever wondered whether you can get by with a trade deficit of $2 billion a day, look at where we find ourselves now. If anyone ever wonders if you can spend money you don't have on things you don't need, look at this country's fiscal policy and its consequences for the country.

Having said that, all of us want the same thing for this country's future. We want a country that grows and provides economic opportunity. We want a country where the fundamentals are fair and put in order. That means a trade deficit that is eliminated, or at least close to eliminated, and a trade policy that works for this country's interest. It means a fiscal policy that pays our bills, and it means effective regulation in areas where you have substantial potential risk for the entire economy, and that means regulation of certain hedge funds' transactions and derivatives now well outside the view of public regulators.

So I think this is going to be a very difficult time for this country. It is one thing for us to take a shower in the morning, put on a suit and drive to work and talk about it, it is another thing for the people who go home tonight and say: Sweetheart, I have lost my job, not because I didn't do a good job, but they are laying people off where I work. That is a consequence for that family in which unemployment is 100 percent.

We face some pretty daunting challenges. My hope with this President and with Republicans and Democrats working together, as the Speaker of the House and the majority leader of the Senate said last week, with all of us working together, combined with the Federal Reserve's monetary policy, that we can develop some thoughtful approaches in fiscal policy that might lead us in a constructive direction to say to the American people we believe you can honestly look at the future and have a positive view. But they won't believe that if they feel we are not serious about the fundamentals. The American people aren't going to be fooled. If we don't fix our trade policies and get rid of these unbelievable deficits, if we don't put our fiscal house in order and stop doing what the administration suggests we do, we are in big trouble.

We had a Treasury Secretary named Paul O'Neill—the first Treasury Secretary under this President. If ever there was a straight shooter in Government, it was Paul O'Neill. He came here as an executive from an aluminum company. He was blunt-spoken, an interesting guy, and I happened to like him a lot. Paul O'Neill got fired. In fact, DICK CHENEY is the one who fired him, at the request of the President. When fired, he was told that deficits don't matter. Deficits don't matter.

Well, we now understand they do matter and we have to do something about it. This fiscal policy is out of control. Our trade policy is broken and we have had regulators who looked the other way while we had grand theft in this area of the subprime scandal, and it is time we tell the American people we are serious about addressing these issues and we are going to do it now.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Ms. STABENOW. Mr. President, I rise today in strong support of the Indian Health Care Improvement Act. I, first, wish to thank our chairman, Senator DORGAN, for his passion and commitment. I have had the opportunity to listen to some of the floor debate and opening comments and very much appreciate the way you have laid out the incredible need for this legislation and the fact it is long overdue.

It is a promise that has not been kept, and hopefully today we are going to move forward in keeping that. Also, thank you to my friend and ranking member, Senator MURKOWSKI, for her eloquence as well in laying out the legislation. It is wonderful to see the partnership that has happened on this legislation.

I also wish to remember our colleague, former Senator Craig Thomas, who I know was a wonderful friend to Indian Country and cared very deeply about these issues. We certainly take a moment again to remember him and send our best wishes to his family in remembrance of his leadership on this issue as well.

Just over 31 years ago, this bill, the original bill, was signed into law by the late President Gerald R. Ford, who I am proud to say resided and represented the great State of Michigan. It had the purpose of bringing the health status of Native Americans up to the level of other Americans.

This program, the Indian Health Services Program, funds health services to about 1.8 million Native Americans from our Nation's more than 500 federally recognized American Indian and Alaskan Native tribes. I am proud to have many of them in Michigan.

The Federal Government provides those health care services based on our trust responsibility to Indian tribes derived from Federal treaties, statutes, court rulings, Executive actions, and from our own Constitution, which assigns authority over Indian relations to the Congress.

Reauthorization of the various Indian health care programs has languished for 15 years in this body, so our work today is vital. It is a vital component, it is long overdue, as our chairman has reminded us over and over again in bringing this issue forward for years.

It is a vital component in improving and updating health care services in Indian Country. The Indian Health Care Improvement Act will modernize and improve Indian health care services and delivery. We know this is an incredibly important step. We know more

needs to be done, but we know this is an incredibly important step.

The bill will also allow for in-home care for Indian elders and will provide much-needed programs to address mental health and other issues related to the well-being of Indian communities.

More importantly, the Indian Health Care Improvement Act will address many health care disparities in Indian Country. For example, infant mortality rates are 150 percent greater for Indians than for Caucasian infants.

Those in the Indian communities are 2.6 times more likely to be diagnosed with diabetes. Tuberculosis rates for Native Americans are four times the national average. The life expectancy for Native Americans is nearly 6 years less than the rest of the U.S. population.

What this bill, unfortunately, cannot do is mandate the necessary funding from our budget every year to uphold our country's trust responsibility to provide adequate health care to our tribal members. But we intend to make sure that happens.

As it stands, the Indian Health Services annual funding does not allow it to provide all the needed care for eligible Native Americans. That is what we are speaking to today, that sense of urgency we have in making that happen.

As of today, funding levels are only at 60 percent of the demand for services each year, which requires IHS tribal health facilities, organizations, and urban clinics to ration care so the most critical care and the needs are funded first and foremost, which, in turn, results in the tragic denial of needed services for too many men, women, and children, old and young in Indian country.

As unbelievable as it may sound, health care expenditures to Native Americans are less than half of what America spends on Federal prisoners.

Preventative health care is so important for Indian Country due to the high incidence of chronic diseases such as diabetes and obesity within these communities. IHS funding shortfalls for medical personnel have only further contributed to the severe gaps in health care delivery in Indian Country. In 2005, there were job vacancy rates of 24 percent for dentists, 14 percent for nurses, 11 percent for physicians and pharmacists, according to IHS data.

I am very pleased and proud to be a cosponsor of this important legislation, as it establishes objectives to address these health disparities between Native Americans and other members of the American community. It will enhance IHS ability to attract and retain qualified health care professionals for Indian Country.

As a government, I am also hopeful we will commit the additional resources to Indian health care for this year and every year in the future. The time has long passed for this reauthorization. I am very proud our leader, Senator REID, has determined this to be a priority for the Senate. I am proud of the work that has been done. It is truly time to get this done now.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. VITTER. Mr. President, I ask unanimous consent to call up my amendment at the desk, Vitter amendment No. 3896.

The PRESIDING OFFICER. Is there objection to setting aside the pending amendment?

Mr. DORGAN. Mr. President, I have not had a chance to visit with the Senator from Louisiana. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. VITTER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

AMENDMENT NO. 3896

Mr. VITTER. Madam President, I ask unanimous consent to call up amendment No. 3896 at the desk.

The PRESIDING OFFICER. Is there objection to setting aside the committee amendment?

Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

The Senator from Louisiana [Mr. VITTER] proposes an amendment numbered 3896.

Mr. VITTER. I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To modify a section relating to limitation on use of funds appropriated to the Service)

Strike section 805 of the Indian Health Care Improvement Act (as amended by section 101(a)) and insert the following:

"SEC. 805. LIMITATION RELATING TO ABORTION.

''(a) DEFINITION OF HEALTH BENEFITS COVERAGE.—In this section, the term 'health benefits coverage' means a health-related service or group of services provided pursuant to a contract, compact, grant, or other agreement.

''(b) LIMITATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no funds or facilities of the Service may be used—

''(A) to provide any abortion; or

''(B) to provide, or pay any administrative cost of, any health benefits coverage that includes coverage of an abortion.

''(2) EXCEPTIONS.—The limitation described in paragraph (1) shall not apply in any case in which—

''(A) a pregnancy is the result of an act of rape, or an act of incest against a minor; or

''(B) the woman suffers from a physical disorder, physical injury, or physical illness that, as certified by a physician, would place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.''.

Mr. VITTER. Madam President, I offer an important amendment with regard to abortion and the pro-life cause. It is a very appropriate day that we talk about this because as we speak tens of thousands upon tens of thousands of people, particularly young people, from all around the country are marching in Washington, on the Mall, at the Supreme Court, in a positive, vibrant march for life. In offering this amendment, I also want to thank all of my original amendment cosponsors: Senators ALLARD, BROWNBACK, THUNE, and INHOFE.

This amendment is very simple. This amendment codifies, solidifies the Hyde amendment policy in this important Indian Health Care Improvement Act. It establishes, reasserts, the policy of the Hyde amendment with regard to the Indian Health Care Improvement Act and puts that Hyde amendment language in the authorization language for this important part of Federal law.

Let me explain why it is necessary. For many years the Hyde amendment has been honored, including in this Federal program, but in a very roundabout and precarious way. For many years this program and this authorization have included language that says: This program will be governed by whatever abortion language is contained in the current Health and Human Services appropriations bill. And for those years, Congress has included Hyde amendment language in that appropriations bill to which this program points. That has worked, sort of, in accomplishing having the Hyde amendment in Federal law with regard to Indian health care, but it puts it in a tenuous and precarious posture. It puts it up for debate and possible change of policy every year, every time we debate a new Health and Human Services appropriations bill. Therefore, it doesn't make the policy very solid, very secure, or very clear.

My amendment is very simple. It would simply place that Hyde amendment language directly in the Indian health care language and say: No Federal funds in this program will be used to perform abortions except in the rare exceptions delineated in the original Hyde amendment.

This is very appropriate. Why should we go to this in such a roundabout and tenuous and precarious way? I think we should place that clear policy, which has been accepted over many years, since the original Hyde amendment debate, directly in the Indian Health Care Improvement Act and not have it sort of get there maybe every year through such a torturous and tenuous and precarious route.

It is very simple. On this day, where tens of thousands upon tens of thousands of Americans, particularly young

people—and that is so heartening—are marching on Washington in a positive march for life, will we clearly reaffirm that Hyde amendment language in the Indian Health Care Improvement Act? I suggest all of us should do that. I suggest that would be a positive statement for life, for positive values for the future. Voting for the amendment will accomplish just that.

I have talked to the chairman of the committee, and he has indicated that a vote will be forthcoming further on in the debate of this bill. I welcome that. I welcome everyone on both sides of the aisle joining together around this consensus amendment to make a positive statement for life, to reaffirm what has been Federal policy for several years, the Hyde amendment, and to move forward, hopefully together, in a positive spirit, making that positive statement for life.

In closing, this is a very important issue and a very important amendment, a very important vote to millions of people around the country who care deeply about life. Because of that, this will be a vote focused on and graded by several key national groups; specifically, the National Right to Life Committee, Concerned Women of America, and the Family Research Council.

I have letters from all three of these groups making clear their strong support of the Vitter amendment and also making clear that this vote on this amendment will be graded in their activity monitoring the Congress. I ask unanimous consent that three letters be printed in the RECORD.

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

NATIONAL RIGHT TO LIFE COMMITTEE, INC.,
Washington, DC, October 23, 2007.

Re Vitter Amendment to S. 1200 (abortion funding).

DEAR SENATOR: The Senate is expected to soon consider S. 1200, the Indian Health Care Improvement Act Amendments of 2007. The National Right to Life Committee (NRLC) urges you to vote for an amendment that Senator Vitter will offer, which would codify a longstanding policy against funding of abortions with federal Indian Health Service (IHS) funds (except to save the life of the mother, or in cases of rape or incest).

For Medicaid, federal funding of abortion was restricted beginning in 1976 by enactment of the Hyde Amendment to the annual HHS appropriations bill. However, because the IHS is funded through the separate Interior appropriations bill, which has never contained a ''Hyde Amendment,'' the IHS continued to pay for abortion on demand long after the Hyde Amendment was enacted. The Reagan Administration curbed the practice administratively in 1982, as a temporary fix. Subsequently, in an IHS reauthorization bill in 1988, Congress enacted 25 U.S.C. §1676, which said that any abortion funding limitations found in the HHS appropriations measure in effect at any given time will also apply to the IHS. That requirement, which would be continued by Section 805 of S. 1200 as reported, provides no real assurance that federal IHS funds will not be used to pay for abortion on demand in the future, because the language of future HHS appropriations bills depends upon a host of legislative and political contingencies. Rather than merely extending such a convoluted arrangement, NRLC urges adoption of Senator Vitter's amendment, which would simply codify the longstanding policy: No federal funds for abortion, except to save the life of the mother, or in cases of rape or incest. The substance of Senator Vitter's amendment is based directly on the version of the Hyde Amendment that has been in effect since 1997, which appears as Section 508 in the current Labor/HHS appropriations bill (H.R. 3043).

In short, if you are opposed to direct federal funding of abortion on demand, you should support the Vitter Amendment. Rejection of the Vitter Amendment would have the effect of leaving the door open to future federal funding of abortion on demand by the IHS.

We anticipate that the roll call on the Vitter Amendment will be included in NRLC's scorecard of key pro-life votes of the 110th Congress. Thank you for your consideration of NRLC's position on this important issue.

Sincerely,

DOUGLAS JOHNSON,
Legislative Director.

OCTOBER 29, 2007.

Hon. DAVID VITTER,
U.S. Senate,
Washington, DC.

DEAR SENATOR VITTER: The 500,000 members of Concerned Women for America are grateful for your continued commitment to the sanctity of life. We appreciate your work to eliminate federal funding of abortions through the Indian Health Care Improvement Act (S. 1200). This amendment will benefit many women and save innocent lives as Indian Health Services (IHS) funds will be prohibited for use for abortions.

Thank you for your work to codify a longstanding policy and ensure that despite the change in partisan politics, this nation will stand for life. A permanent adoption of this policy to the IHS program will be a positive step in the direction of upholding our nation's claim to the sanctity of life.

The Hyde amendment of 1976 restricted the federal funding of abortion through Medicaid, but this policy did not apply to the IHS due to its receiving funding through a separate Interior Appropriations bill. The IHS continued to pay for abortion on demand until 1982. This was six years too long. Though the Reagan administration administratively curbed the practice, future administrations have not been and will not be barred from paying for abortion on demand using IHS funds.

Senator Vitter, that is why we are grateful for your pro-life amendment to S. 1200. Legislative policies are needed to ensure that the sanctity of life is not subject to partisan politics. We appreciate your commitment to prohibit the federal government from funding abortion on demand.

Sincerely,

WENDY WRIGHT,
President,
Concerned Women for America.

FAMILY RESEARCH COUNCIL,
Washington, DC, January 14, 2008.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of Family Research Council and the families we represent, I want to urge you to vote for the amendment offered by Senator David Vitter (R–LA) to the Indian Health Care Improvement Act of 2007 (S. 1200) which would prevent Indian Health Service funds from being used for abortion. Exceptions would include cases where the life of the mother is at risk, or in the case of rape or incest with a minor. We strongly support this amendment.

Current federal law since the 1988 Indian Health Care reauthorization limits Indian Health Service funds from being used to perform abortion. It does so by referencing the Hyde provision in the annual LHHS appropriations bill, which prohibits such funding for abortion. S. 1200 in Section 805 reiterates this reference to the Hyde provision. However, if the Hyde provision were removed from the LHHS appropriations bill, funding of abortion under Indian Health Services would ensue.

Senator Vitter's amendment language is similar to the Hyde provision and would simply codify this long-standing policy in the Indian Health Care Improvement Act. As such, federal Indian Health Service funds would not be used for abortions, no matter what happens with the Hyde provision in future appropriations cycles.

Your support for the Vitter amendment will uphold the long-standing policy that United States taxpayers should not subsidize abortion. FRC reserves the right to score votes surrounding this amendment in our scorecard for the Second Session of the 110th Congress to be published this fall.

Sincerely,

THOMAS MCCLUSKY,
Vice President for Government Affairs.

Mr. VITTER. Again, in closing, I welcome all of our colleagues to support this commonsense, pro-life, positive amendment. I look forward to any further debate on it, to answer any questions that might arise, and to an important vote before we conclude consideration on this bill.

I yield the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

(The remarks of Mr. SPECTER pertaining to the introduction of S. 2539 and S. 2540 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Ms. KLOBUCHAR. Madam President, I come to the floor today to talk about my support for the reauthorization of the Indian Health Care Improvement Act. I am a cosponsor of this bill because there is a vital need for our Native American communities to have access to modernized health care.

Today, the health disparities between our tribal communities and the rest of the country are shocking. According to the Indian Health Service, the average life expectancy for Native Americans is almost 2½ years below any other group in the country. The incidence of sudden death syndrome among tribal communities is more than three times the rate of nontribal infants. If you are a Native American, you are 200 percent more likely to die of diabetes, you are 500 percent more likely to die from tuberculosis, you are 550 percent more

likely to die from alcoholism, and you are 60 percent more likely to commit suicide.

These may seem like nothing but statistics, but behind them are real people who are in real need of modernized health care services.

The suicide rate among Native American youth is the highest of any racial group in the Nation. In fact, suicide is the third leading cause of death among Native American youth. One of the country's most recent victims is a 12-year-old Red Lake boy who hanged himself last October. This young boy's suicide only added to the heartache of the Red Lake Indian Reservation, which is located in my State of Minnesota. This Indian reservation, the people there had already suffered a lot. Back in March of 2005, at the Red Lake High School, a troubled teenager named Jeff Weise went on a shooting rampage, killing nine people before turning the gun on himself. Most of the news reports highlighted the troubled teen's past, including a history of depression and suicide attempts and the daunting socioeconomic conditions in his reservation community. This calamity serves as a tragic reminder of the importance of increasing efforts to effectively address mental health issues in Indian Country and elsewhere. I know my colleague, Senator DORGAN, has been leading this effort, this bipartisan effort, to make sure we reauthorize this important act.

We know the negative impact mental health issues have on our communities, but we also know access to modern mental health care resources can make a difference. That is why it is so critical to reauthorize the Indian Health Care and Improvement Act.

Reauthorizing this bill will provide tribal communities with the tools needed to build comprehensive behavioral health prevention and treatment programs—programs that emphasize collaboration among alcohol and substance abuse, social services, and mental health programs, and programs that will help communities such as Red Lake prevent further tragedies.

Reauthorizing this bill will also help tribal communities attract and retain qualified Indian health care professionals and address the backlog in needed health care facilities on Indian reservations. I have visited the facilities. I visited the reservations throughout my State, and I know they are in need of this help. The lack of availability of nearby health care facilities and specialized treatment is a major concern for tribal communities, especially those with large reservations.

On the Minnesota White Earth Indian Reservation, which is the largest reservation in our State, spanning 200 miles and home to almost 10,000 people, elective surgeries are not even an option—in an area that spans 200 miles—due to a lack of modernized health care resources and facilities. Currently, these White Earth tribal members are unable to undergo elective surgery on the reservation. These are people who need a hip replacement or a knee replacement or a simple cataract surgery, but they are unable to get the health care they deserve because there is a lack of doctors, adequate medical facilities, and basic insurance coverage.

The Federal Government has a trust responsibility to provide health care for our tribal communities. I cosponsored the Indian Health Care Improvement Act because we made a commitment to our tribal communities. We must ensure our tribal communities have access to convenient, preventive, and modern health care. I urge my colleagues to join me and support reauthorizing this important bill.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. DORGAN. Madam President, I believe Senator NELSON of Florida is on his way. Before that, the legislation we brought to the floor from the Committee on Indian Affairs has been worked on for a long while. It is long past due to be considered by the Congress. It deals with the urgent need for Indian health care.

I want to especially say we worked with the National Indian Health Board on this legislation and Sally Smith, chair of the board; with the Tribal Leaders Steering Committee on Indian Health, Buford Rollin, cochair, and Rachel Joseph, cochair. We worked closely with the National Congress of American Indians, Joe Garcia, president, and Jackie Johnson, executive director. We held listening sessions at many Indian reservations to talk about the challenges and what we need to do to resolve these issues.

I wish to mention as well today we have from the White House a statement of administration policy in which the White House is talking about a potential veto of this legislation. That is not particularly unusual. The White House has been talking about vetoing almost anything and everything for the last several months. So I am not particularly surprised. My hope is we can work with the White House. This is a bipartisan piece of legislation. We expect to pass it through the Congress, and my hope is the President will sign it.

I wish to address one of the issues the White House is concerned about—the Indian urban health care program. The President has requested we not have any funding for it, that we discontinue the urban Indian health care program. My colleague, Senator MURKOWSKI, and I and many others have disagreed with that. We believe there is a need for the urban Indian health care program.

I wish to describe that need by describing one person, a Native American, the late Lyle Frechette. This is a photograph taken after he finished high school. He was a member of the Menominee Tribe of Indians in Wisconsin. He was a proud veteran, who went into the Marine Corps right after high school, when this picture was taken. After serving his country as a U.S. marine, he came home to the Indian reservation to find life had significantly changed. That was at a time in this country when we were going through what is called ''termination and relocation.'' The policy in this country was to say to American Indians that we want to get you off the reservation and to a city someplace.

In fact, the official policy of the Federal Government was to terminate government-to-government relationships with 109 Indian tribes during that period, the early 1950s. It was suggested, well, let's terminate relationships with tribes and say to these Indians: Go to the city and leave your reservation. So many did, and Lyle Frechette did. The movement from a tribal reservation, where there was some Indian health care, although inadequate, to the major cities meant that Lyle Frechette was leaving an area that had vast forests and timber resources that represented financial stability for the Menominee Tribe. Yet the Federal Government thought this was a great candidate for termination. So they took steps to terminate the tribal status.

That termination had catastrophic effects on the lives of many of the tribal governments and the people who were members of the tribes. It required many of the young tribal members, such as Lyle Frechette, to either stay on the reservation and live in abject poverty, with no further health or any benefits that had long been promised to them, or participate in the Federal urban relocation program. Often, they were given a one-way bus ticket and told good luck; they ended up in cities with substantial limitations on what they could do.

Lyle Frechette had a young wife and a child and they relocated to Milwaukee, WI, 3½ hours from the reservation. He no longer had access to health care on the Indian reservation. There were very few urban clinics and the relocated Indians only qualified for private sector insurance for 6 months, and that was over. Health care is essential. Many of these folks, including this young man, left the reservation because of the termination and relocation program and discovered they were not able to access health care programs.

Then, over a period of years, urban health care programs were established to try to be helpful to those whom we had literally forced off the reservations. The fact is it has been a life-saving experience for many urban Indians to be able to access that which was guaranteed them as part of the trust responsibility of the Federal Government to American Indians, even being

able to access that in some of our urban areas. The President has wanted to shut down that program. We have said we don't support that, on a bipartisan basis. Congress has said the urban health care programs for American Indians has worked very well.

I wished to describe that issue because the President indicated that is one of the issues in his letter and the statement of administrative policy today in which he suggests he may well veto this legislation. I hope he will not and that we will work on a bipartisan basis to convince the President doing this is the right thing to do.

I know my colleague from Florida is here ready to speak. At this point, I yield the floor, and my colleague wishes to be recognized.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Madam President, I wish to say to the very distinguished Senator from North Dakota he has always been one of the foremost advocates for improving Indian health on the tribal lands, and I intend to support him. I thank him for his advocacy.

In my State of Florida, we have a number of very prominent Indian tribes, the Seminoles, the Mikasukis, and others. The good fortune is they do not have the health problems other tribes have throughout other parts of the country. Yet there are some problems in Florida as well. This is a matter we cannot continue to close our eyes to. We need to help them. I intend to support the Senator from North Dakota on this bill. I look forward to its passage and, hopefully, working out the problems with the White House so they will not veto this legislation.

Madam President, I wish to talk about this. We are now obviously in a recession: the gyration of the stock market, the weakness of the dollar, the roiling markets around the world, the emergency meeting of the Federal Reserve, the cutting of the rate three-quarters of a percent, from 4¼ to 3½, the likelihood they will meet again next week and cut the interest rate further. We are in a full-scale recession.

I have returned from my State of Florida and this recess having done town hall meetings all over the State, in which the town halls were packed, with standing room only. They were out into the hallways. They were hungry to be heard, and that is the way I conduct those town hall meetings. I go in and say: This is your meeting, and I want to hear what is on your mind, what your concerns are, and I want to know how you are hurting, so we can try to help you. We pick up huge numbers of cases for our caseworkers as a result of these outreach town hall meetings all over my State.

Let me remind you my State is the fourth largest in the Union and by 2012 it will surpass New York and will be the third largest in the Union. In that midst of 18 million people who are as diverse as America, indeed becoming as diverse as the Western Hemisphere, people are hurting. In addition to the global and national economies, our people are triply hurting by getting the double whammy of increased real estate taxes, as well as huge increases in homeowners insurance. We talked about this crisis many times on the floor—about an appropriate Federal role to assist the States with regard to insurance markets that have gone out of control, jacking the rates to the Moon, in the anticipation of another catastrophe following Katrina in New Orleans and the previous year, 2004, four hurricanes that hit Florida within a 6-week period.

All those things have come together, so that I can tell you in these 15 town hall meetings I did, from literally one end of Florida, Key West, to the other, Pensacola, people are hurting. You take a very upscale, increasingly hot economy, such as Fort Myers, Lee County, they are in the economic doldrums. They are hurting. Go to your rural areas. We always talk about rural health care. It is certainly true there. But the rural areas are depressed. The jobs have diminished. Unemployment has gone up. The people are concerned about their investments. The main investment the average Florida family has is their home. If they need cash and need to sell their home, now they cannot sell their home because there is a complete flat market; and if they need cash, trying to get an additional loan because of equity, the banks are not loaning. So you get the picture of what is happening in Florida. Indeed, Florida is the microcosm of America. This is happening all over America.

Now, what we have already voted on in the Senate is a first step. But it is a small step. We have voted on, and I have supported, mortgage forgiveness debt relief so if a bank were to forgive part of the loan, we want to change the Tax Code so the homeowner doesn't have to pay income tax on that reduction in the amount of the loan the bank grants them, to try to keep them solvent so they can continue to pay off the loan.

We are also supporting property tax relief, which is that 32 million homeowners, or 70 percent of taxpayers, do not itemize their real estate property taxes, and of that 70 percent, 32 million of those are homeowners. What we are suggesting is that we give them a standard deduction, so if you own real estate property and you don't itemize your deductions, there will be a standard deduction that will be available.

And then in December the Senate passed, and this Senator voted for, the Federal Housing Administration Modernization Act. It was intended to help homeowners in the risky subprime mortgages to be able to refinance them through the FHA into more reliable mortgages. These are all attempts at getting at the problem. But that was December and this is now late January and the economy has slipped further and deeper into recession. So we need to come out in a bipartisan way with a fix that will help stimulate the economy and try to get us back on track: increasing unemployment compensation perhaps from the 26 weeks to as many as 46 weeks; the ability to go in and put money quickly in somebody's pocket, such as a reduction of the payroll taxes, that in those every 2-week paychecks, they will see an increase in that take-home pay; perhaps for those who are hurting the most at the lower end of the economic scale, additional food stamps; infrastructure support that would get money into the economy, stimulating and turning over those dollars into the economy if it is invested in items that can be spent immediately in the much needed repair of roads and bridges.

Whatever the ideas are, there is going to be an ideological divide. Let's hope it does not come down to this question of taxing the poor and giving the tax breaks to the more well off. That is not going to give the economic stimulus this country needs. And then approaching this question of all these defaulted loans or the ones that are about to be defaulted, over and above what we have already attempted to do in December, is something that we must address. What is the appropriate action, not to reward those who were gaming the system, but for those who are genuinely hurting because they either did not know or they were deceived into signing a mortgage that lulled them along with cheap interest rates and then all of a sudden has an escalation of that interest rate that they cannot pay.

A combination of all these actions is what we ought to think about and come up with a stimulus package very soon in a bipartisan way. Let's in the Senate rise above the petty partisan politics that has so dominated this Chamber now for the last several years. Let's rise and come together and help our people with a quick passage of a stimulus package that will get America back on the economic track.

FLORIDA PRIMARY

I end by saying a word or two about a completely different subject. It has been painful for this Senator to see the Democratic candidates for President stay out of my State of Florida because they had to sign a pledge that was insisted upon by the four first privileged States—Iowa, New Hampshire, Nevada, and South Carolina—even though it was a Republican State legislature, signed into law by a Republican Governor of Florida, moving the primary 1 week before super Tuesday, February 5, to the Florida primary date of January 29, those four privileged States insisted that the candidates sign a pledge or else suffer the consequences in those early four States.

The pledge was that they would not campaign in Florida, they would not hire staff in Florida, they would not open an office, they would not make telephone calls, they would not make advertisements, they would not, can you believe, have press conferences.

This Senator thinks that the first amendment protections have been shredded. Nevertheless, that is what the Democratic candidates did, and they have stayed out of Florida.

The Republican National Committee, not taking away all the delegates as the Democratic National Committee did from Florida, took away half the Republican delegates from Florida but did not extract such a pledge. Thus, since the South Carolina primary was already held for the Republicans, and it is still to be held this Saturday for the Democrats, we see the Republicans en masse in Florida campaigning, much to the chagrin of Florida Democrats who do not see their candidates.

What is going to happen is that next Tuesday, Florida is going to vote; Florida, 18 million people, the first big State to vote, the first State that is representative of the country as a whole in almost any demographic that we line up with the country, it is going to vote, and it is going to cast its ballots for President of both parties, and it is going to be reported how Florida votes. It is definitely going to have an effect 7 days going into super Tuesday when 22 States vote.

Senator LEVIN of Michigan and I have filed a bill that will bring some order out of this chaos. There should not be a person in America who thinks this is the way to nominate a President of the United States for their party. If we continue to allow this kind of chaos going on, the States will continue to leapfrog each other, and the first primary will be at Halloween.

This is not a good way of selecting nominees. Senator LEVIN and I have suggested a more orderly system that I will describe in detail at a later time but that would have six primaries: the first in March, two in April, two in May, and the last one in June, through which the States, large and small, geographically distributed, would each, according to the sequence of which they would draw out of a hat one to six, proceed on that order. Four years later, they would rotate. The ones second would go first, and the ones first would go to the last primary in June, 4 years down the road in the next Presidential cycle.

We have to bring order out of this chaos. In the meantime, I am here as Florida's senior Senator to say and to let all those Presidential candidates know that Florida takes its vote very seriously. Florida will express herself in both parties. Florida will have the influence of the first big State, and by the time we get to the conventions in August and September, the entire Florida delegation will be seated and voted.

So I ask the Presidential candidates to consider the frustration and the consternation on the Democratic side as we approach our Florida Presidential primary on January 29.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas.

AMENDMENT NO. 3893

Mr. BROWNBACK. Madam President, I ask unanimous consent that the pending business be set aside and that my amendment, No. 3893, be called up.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Kansas [Mr. BROWNBACK] proposes an amendment numbered 3893.

Mr. BROWNBACK. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To acknowledge a long history of official depredations and ill-conceived policies by the Federal Government regarding Indian tribes and offer an apology to all Native Peoples on behalf of the United States)

At the end, add the following:

TITLE III—MISCELLANEOUS

SEC. 301. RESOLUTION OF APOLOGY TO NATIVE PEOPLES OF UNITED STATES.

(a) FINDINGS.—Congress finds that—

(1) the ancestors of today's Native Peoples inhabited the land of the present-day United States since time immemorial and for thousands of years before the arrival of people of European descent;

(2) for millennia, Native Peoples have honored, protected, and stewarded this land we cherish;

(3) Native Peoples are spiritual people with a deep and abiding belief in the Creator, and for millennia Native Peoples have maintained a powerful spiritual connection to this land, as evidenced by their customs and legends;

(4) the arrival of Europeans in North America opened a new chapter in the history of Native Peoples;

(5) while establishment of permanent European settlements in North America did stir conflict with nearby Indian tribes, peaceful and mutually beneficial interactions also took place;

(6) the foundational English settlements in Jamestown, Virginia, and Plymouth, Massachusetts, owed their survival in large measure to the compassion and aid of Native Peoples in the vicinities of the settlements;

(7) in the infancy of the United States, the founders of the Republic expressed their desire for a just relationship with the Indian tribes, as evidenced by the Northwest Ordinance enacted by Congress in 1787, which begins with the phrase, ''The utmost good faith shall always be observed toward the Indians'';

(8) Indian tribes provided great assistance to the fledgling Republic as it strengthened and grew, including invaluable help to Meriwether Lewis and William Clark on their epic journey from St. Louis, Missouri, to the Pacific Coast;

(9) Native Peoples and non-Native settlers engaged in numerous armed conflicts;

(10) the Federal Government violated many of the treaties ratified by Congress and other diplomatic agreements with Indian tribes;

(11) the United States should address the broken treaties and many of the more ill-conceived Federal policies that followed, such as extermination, termination, forced removal and relocation, the outlawing of traditional religions, and the destruction of sacred places;

(12) the United States forced Indian tribes and their citizens to move away from their traditional homelands and onto federally established and controlled reservations, in accordance with such Acts as the Act of May 28, 1830 (4 Stat. 411, chapter 148) (commonly known as the ''Indian Removal Act'');

(13) many Native Peoples suffered and perished—

(A) during the execution of the official Federal Government policy of forced removal, including the infamous Trail of Tears and Long Walk;

(B) during bloody armed confrontations and massacres, such as the Sand Creek Massacre in 1864 and the Wounded Knee Massacre in 1890; and

(C) on numerous Indian reservations;

(14) the Federal Government condemned the traditions, beliefs, and customs of Native Peoples and endeavored to assimilate them by such policies as the redistribution of land under the Act of February 8, 1887 (25 U.S.C. 331; 24 Stat. 388, chapter 119) (commonly known as the ''General Allotment Act''), and the forcible removal of Native children from their families to faraway boarding schools where their Native practices and languages were degraded and forbidden;

(15) officials of the Federal Government and private United States citizens harmed Native Peoples by the unlawful acquisition of recognized tribal land and the theft of tribal resources and assets from recognized tribal land;

(16) the policies of the Federal Government toward Indian tribes and the breaking of covenants with Indian tribes have contributed to the severe social ills and economic troubles in many Native communities today;

(17) despite the wrongs committed against Native Peoples by the United States, Native Peoples have remained committed to the protection of this great land, as evidenced by the fact that, on a per capita basis, more Native Peoples have served in the United States Armed Forces and placed themselves in harm's way in defense of the United States in every major military conflict than any other ethnic group;

(18) Indian tribes have actively influenced the public life of the United States by continued cooperation with Congress and the Department of the Interior, through the involvement of Native individuals in official Federal Government positions, and by leadership of their own sovereign Indian tribes;

(19) Indian tribes are resilient and determined to preserve, develop, and transmit to future generations their unique cultural identities;

(20) the National Museum of the American Indian was established within the Smithsonian Institution as a living memorial to Native Peoples and their traditions; and

(21) Native Peoples are endowed by their Creator with certain unalienable rights, and among those are life, liberty, and the pursuit of happiness.

(b) ACKNOWLEDGMENT AND APOLOGY.—The United States, acting through Congress—

(1) recognizes the special legal and political relationship Indian tribes have with the United States and the solemn covenant with the land we share;

(2) commends and honors Native Peoples for the thousands of years that they have stewarded and protected this land;

(3) recognizes that there have been years of official depredations, ill-conceived policies, and the breaking of covenants by the Federal Government regarding Indian tribes;

(4) apologizes on behalf of the people of the United States to all Native Peoples for the many instances of violence, maltreatment, and neglect inflicted on Native Peoples by citizens of the United States;

(5) expresses its regret for the ramifications of former wrongs and its commitment to build on the positive relationships of the

past and present to move toward a brighter future where all the people of this land live reconciled as brothers and sisters, and harmoniously steward and protect this land together;

(6) urges the President to acknowledge the wrongs of the United States against Indian tribes in the history of the United States in order to bring healing to this land by providing a proper foundation for reconciliation between the United States and Indian tribes; and

(7) commends the State governments that have begun reconciliation efforts with recognized Indian tribes located in their boundaries and encourages all State governments similarly to work toward reconciling relationships with Indian tribes within their boundaries.

(c) DISCLAIMER.—Nothing in this section—

(1) authorizes or supports any claim against the United States; or

(2) serves as a settlement of any claim against the United States.

Mr. BROWNBACK. Madam President, I thank my colleague from North Dakota, the chairman of the Indian Affairs Committee, who has been a sponsor of this bill that I put in amendment form and am calling up now as an amendment, as an official apology to Native Americans in the United States for past issues. It is an amendment with a lot of history to it.

The bill has been brought up this Congress, the last Congress, and it has passed the Indian Affairs Committee both Congresses. It is an amendment with an issue of a lot of history to it. The chairman and myself are from Plains States where there is a lot of Native American history, as there is throughout the United States. It is a history that is both beautiful, difficult, and sad at the same time.

I have four tribal lands in my State, four areas where there are tribal lands, some that are tribal but don't have a resident tribe in the State. This has been an issue that has been around for some time—the relationship between the Federal Government and the tribes.

What we have crafted in this amendment, a previous bill that is now in amendment form, is an official apology. It does not deal with property issues whatsoever, but it recognizes some of the past difficulty in the relationship.

It says that for those times the Federal Government was wrong, we acknowledge that and apologize for it. Apologies are difficult and tough to do, but I think this one is meritorious and, as I present my case, I hope my colleagues will agree and support this amendment.

I rise today to speak about this issue that I believe is important to the well-being of all who reside in the United States. It is an issue that has lain unresolved for far too long, an issue of the United States Government's relationship with the Native peoples of this land.

Native Americans have a vast and proud legacy on this continent. Long before 1776 and the establishment of the United States of America, Native peoples inhabited this land and maintained a powerful physical and spiritual connection to it. In service to the Creator, Native peoples sowed the land, journeyed it, and protected it. The people from my State of Kansas have a similar strong attachment to the land.

Like many in my State, I was raised on the land. I grew up farming and caring for the land. I and many in my State established a connection to this land as well. We care for our Nation and the land of our forefathers so greatly that we too are willing to serve and protect it, as faithful stewards of the creation with which God has blessed us. I believe without a doubt citizens across this great Nation share this sentiment and know its unifying power. Americans have stood side by side for centuries to defend this land we love.

Both the Founding Fathers of the United States and the indigenous tribes that lived here were attached to this land. Both sought to steward and protect it. There were several instances of collegiality and cooperation between our forbears—for example, in Jamestown, VA, Plymouth, MA, and in aid to explorers Lewis and Clark. Yet, sadly, since the formation of the American Republic, numerous conflicts have ensued between our Government, the Federal Government, and many of these tribes, conflicts in which warriors on all sides fought courageously and which all sides suffered. Even from the earliest days of our Republic there existed a sentiment that honorable dealings and a peaceful coexistence were clearly preferable to bloodshed. Indeed, our predecessors in Congress in 1787 stated in the Northwest Ordinance:

The utmost good faith shall always be observed toward the Indians.

Many treaties were made between the U.S. Government and Native peoples, but treaties are far more than just words on a page. Treaties represent our word, and they represent our bond. Treaties with other governments are not to be regarded lightly. Unfortunately, again, too often the United States did not uphold its responsibilities as stated in its covenants with Native tribes.

I have read all of the treaties in my State between the tribes and the Federal Government that apply to Kansas. They generally came in tranches of three. First, there would be a big land grant to the tribe. Then there would be a much smaller one associated with some equipment and livestock, and then a much smaller one after that.

Too often, our Government broke its solemn oath to Native Americans. For too long, relations between the United States and Native people of this land have been in disrepair. For too much of our history, Federal tribal relations have been marked by broken treaties, mistreatment, and dishonorable dealings. I believe it is time to work to restore these relationships to good health. While the record of the past cannot be erased, I am confident the United States can acknowledge its past failures, express sincere regrets, and work toward establishing a brighter future for all Americans. It is in this spirit of hope for our land that I am offering Senate Joint Resolution 4, the Native American Apology Resolution, as an amendment to the bill currently before us. This resolution will extend a formal apology from the United States to tribal governments and Native peoples nationwide—something we have never done; something we should have done years and years ago.

I want my fellow Senators to note this resolution does not—does not—dismiss the valiance of our American soldiers who fought bravely for their families in wars between the United States and a number of the Indian tribes, nor does this resolution cast all the blame for the various battles on one side or another.

Further, this resolution will not resolve the many challenges still facing Native Americans, nor will it authorize, support or settle any claims against the United States. It doesn't have anything to do with any property claims against the United States. That is specifically set aside and not in this bill. What this resolution does do is recognize and honor the importance of Native Americans to this land and to the United States in the past and today and offers an official apology for the poor and painful choices the U.S. Government sometimes made to disregard its solemn word to Native peoples. It recognizes the negative impact of numerous destructive Federal acts and policies on Native Americans and their culture, and it begins—begins—the effort of reconciliation.

President Ronald Reagan spoke of the importance of reconciliation many times throughout his Presidency. In a 1984 speech to mark the 40th anniversary of the day when the Allied armies joined in battle to free the European Continent from the grip of the Axis powers, Reagan implored the United States and Europe to ''prepare to reach out in the spirit of reconciliation.''

Martin Luther King, whom we recognized and celebrated yesterday, who was a true reconciler, once said:

The end is reconciliation, the end is redemption, the end is the creation of the beloved community.

This resolution is not the end, but perhaps it signals the beginning of the end of division and a faint first light and first fruits of the creation of beloved community. This is a resolution of apology and a resolution of reconciliation. It is a step toward healing the wounds that have divided our country for so long—a potential foundation for a new era of positive relations between tribal governments and the Federal Government.

It is time—as I have stated, it is way past time—for us to heal our land of division, all divisions, and bring us together. There is perhaps no better place than in the midst of the Senate's consideration of the Indian Health Care Improvement Act reauthorization to do

this. With this in mind, I hope my Senate colleagues will support this amendment. I would ask their consideration on it. I would ask for their positive vote for it.

I hope a number of my colleagues in the Senate will join me as a cosponsor of the amendment itself so we can show a united front and that it is time for us to heal. I ask they give us that consideration. I simply ask my colleagues to look for this, and I hope they can vote for it as well.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Madam President, I thank the Senator from Kansas. I am a cosponsor in support of the amendment he has offered.

If one studies the history in this country with respect to Indian tribes, it is a tragedy. It is very hard for someone to study it, understand it, and not wish our country to apologize for it. We entered into treaties with the tribes; agreements, signed treaties, with the tribes. We took tribal homelands and pushed them onto reservations and made agreements, including trust agreements, to provide for their health care and many other things.

Then we decided we wanted to push them off reservations and move them into urban areas. Then we decided we would discontinue a government-to-government relationship with 109 tribes. We terminated the tribal status of 109 tribes, and we told these folks to leave the reservations and here is a one-way ticket. We want you to go to the cities to be assimilated into the cities. So we sent them off to the cities, far away from families and health care facilities. Then we sent them off to boarding schools and terminated their governmental status. We took lands off protected trust status and then turned, once again, and began to revitalize tribal language and culture and governments.

When you understand what this country has done, in terms of abrogating agreements and treaties it has made, one can understand the words of Chief Joseph. Here is what Chief Joseph said:

> Good words do not last long unless they amount to something. Good words do not pay for my dead people. Good words cannot give me back my children. Good words will not give my people good health and stop them from dying. I am tired of talk that comes to nothing. It makes my heart sick when I remember all of the good words and then all of the broken promises.

Chief Joseph was an honorable Indian leader. He negotiated face-to-face with the leaders of our country. And while he lived, he saw promise after promise after promise broken. U.S. Supreme Court Justice Hugo Black wrote:

> Great nations, like great men, should keep their word.

That is all Chief Joseph and so many other Indian leaders asked, and it was never granted. We are trying now, in some small and some significant ways, to remedy and address these issues. The Indian Health Care Improvement Act is one step in the right direction to say this country will start to keep its promise, its promise, as a trust responsibility, to provide health care for American Indians.

I say to my colleague from Kansas, I used a chart earlier today to say the American people, the American Government, is responsible, because of treaty obligations and a trust obligation, a trust obligation we have for American Indians, to provide health care to two groups of people. One group is incarcerated Federal prisoners. That is our charge. We put them in prison for crimes, we are required to provide for their health care in Federal prisons. We also have a responsibility for health care for American Indians because of the trust responsibility and treaties by which we made that promise.

Compare the two. We spend twice as much money providing health care for incarcerated prisoners in Federal prisons as we do providing health care to American Indians. And that is why today it is likely somewhere on an Indian reservation someone is dying who shouldn't have to die. Some young child is suffering who shouldn't have to suffer because the health care we expect for our families is not available to them.

If I might, for another minute, say once again that I showed a picture this morning of a young girl named Ta'Shon Rain Littlelight. She died at the age of 5. Ta'Shon Rain Littlelight didn't get the health care most of us would expect for our children. She was a beautiful young child on the Crow reservation, and she spent the last 3 months of her life in unmedicated pain. Finally, she was diagnosed with a terminal illness. And when she was, and I talked about this earlier, she asked to go to see Cinderella's castle, and so the Make-A-Wish Foundation sent her and her mother to Orlando. In the hotel, on the night before she was to see Cinderella's castle, she died in her mother's arms. As she lay in her mother's arms, she said: Mommy, I will try not to be sick. Mommy, I will try to get better.

This young girl, time after time after time, had been taken to the clinic and was diagnosed and treated for depression at the age of 5 when, in fact, she had terminal cancer and she is now dead. A beautiful young girl—Ta'Shon Rain Littlelight. This is happening across our country, and we have to stop it. It is our responsibility to stop it.

My colleague from Kansas offers a resolution that talks about past abuses, and they are unbelievable. But some of them continue, and that is the purpose of this bill and the reason I appreciate his support for the underlying bill. But I did wish to say I am a cosponsor of the amendment offered by Senator BROWNBACK. It is the right thing for our country to do. I am proud to cosponsor what he is suggesting to the Senate today. He is offering it now as an amendment. I have previously cosponsored it as a bill when he has introduced it in the Senate.

So my thanks to the Senator from Kansas. And after he speaks, Madam President, I know the Senator from Ohio wishes to be recognized. But I suspect the Senator from Kansas wishes to say a word, at which point I am happy the Senator from Ohio is here and wishes to speak on this bill.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I wished to thank my colleague from North Dakota, and I would ask the amendment be referred to as the Brownback-Dorgan amendment, if that would be acceptable to my colleague. We will put it forward that way because he has been lead sponsor of this for the past several Congresses, and I appreciate his hard work.

I appreciate his heart and his practicality on the current situation. We do have to get better health care on the reservations and for the Native tribes. I appreciate the effort to get that done, and I think that is an important effort for us and a very practical and necessary thing, so the examples he talks about, and unfortunately so many others, don't continue to happen across this country.

The amendment put forward by my colleague from Louisiana, Senator VITTER, is also important, his view about codifying a situation regarding abortions with Native Americans. I would hope that would be something we could see passed as something that is a hopeful sign in pushing to the future, rather than a sign of despair and the killing of children, which I think is completely wrong for us to see taking place and for us to be funding it as well.

I am delighted this bill is coming up. I think this is an important issue for us to debate, and I am glad to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Madam President, Wall Street and international markets are clearly concerned or worse over a possible U.S. recession. Congress is formulating, as we know—the President, both parties' leadership, the Members of the House and Senate—an economic stimulus package, which is the right thing to do, but there are several pieces to this puzzle. The economy is faltering, to be sure, and we have those concerns about our economy as a whole. Equally important, I would argue more importantly, more Americans are losing access to basic necessities because of it.

A stimulus package should do two things. First of all, a stimulus package needs to stimulate the economy so we can pull ourselves more quickly and more vigorously, if you will, out of this recession. A stimulus package also, equally or more importantly, needs to help those people who have been most victimized by the recession.

I rise to urge this body to take responsibility for helping those who are

without food, without adequate heat, and without adequate housing; those for whom the economic crisis is not just a source of anxiety, in some sense it is a thief in the night who has robbed Americans of basic human needs.

In December, I spoke about the crisis food banks across our Nation face. It was the lead-up to Christmas, a time when the spirit of giving is at its peak. The holidays are now over and we are deep into January. Not surprisingly, food bank donations have fallen off precipitously. Yet the need for food grows as the economic crisis deepens.

Across this country more Americans are in need of food assistance and less food is available. The result is hunger. In the wealthiest Nation in the world, people are waiting in line for a subsistence level of food, food that runs out too often before the lines run out. People who live in the communities we serve are facing increasing food insecurity. In too many cases, people don't know from where their next meal will come.

Increasingly, these are families with children. Food banks in Ohio and Virginia and Arizona and California and in the Presiding Officer's home State of Missouri, in Colorado and every State in the Union are underfunded, overextended. The unemployed, the sick, the aged, the homeless, the mentally ill—these are the individuals who typically seek food banks and food pantries for assistance. And now more working families are also being forced to seek food assistance as factories close and as gas prices and transportation prices—the cost of transportation goes up for people driving to work, wages stagnate, food prices go up, and daily necessities become more expensive.

Five years ago, the Food Bank of Southeast Virginia reported serving 95,000 people—95,000 people in 2002. In 2007, that food bank served 203,000. Forty-two percent of their recipients are categorized as working poor, a population that is on the rise.

In Warren County, OH, a generally affluent county northeast of Cincinnati—the county seat is Lebanon, which I visited last week—in that county, 90 percent of people who go to food pantries have jobs, 90 percent of them are working. They are working often in part-time jobs, often in full-time jobs without benefits, always in jobs that cannot pay their bills.

For many years, one of my constituents, Tim, and his wife donated time and money to Cleveland-area food banks and soup kitchens. But over time, cash for Tim and his wife became tight. They stopped giving money to the food bank; they continued to donate their time to the food bank. This year, after months of rationing food in their own household, Tim and his wife were forced to use the food bank themselves. It took great humility, Tim recalls. Tim says he used to be middle class, but he does not see himself as middle class anymore. He says his wages have not kept pace with subsistence expenses. What he gets from the food bank is not enough either. The groceries he receives last his household about 1 week. Food distributions are limited to once a month.

In Ohio, 70 percent of food pantries do not have enough food to serve everyone in need. This problem is not unique to Ohio. It is affecting cities across the country, with Denver and Orlando and Phoenix particularly hard-hit. American's Second Harvest, the nationwide food bank network, projected a food shortage of 15 million pounds—11.7 million meals—by the end of 2007.

Congress must act swiftly to alleviate the current food shortage. That is why I introduced last month legislation that would allocate $40 million in emergency assistance—$40 million is all. Just to put it in perspective, we are spending $3 billion a week on the war in Iraq. We are asking for $40 million in short-term emergency funding for the Emergency Food Assistance Program, so-called TEFAP.

With legislators still negotiating the details of the farm bill, critical TEFAP funding, which provides food at no cost to low-income Americans in need of short-term hunger relief, has dried up at the worst possible time. This bill will provide the funding necessary to keep food banks funding intact until the farm bill is signed into law.

On a cold December morning about a month ago in southeast Ohio, in the town of Logan, at 3:30 in the morning—3:30 in the morning—people began to line up at a food bank at the Smith Chapel United Methodist Church pantry. By 8 o'clock, about 4½ hours later, when volunteers began distributing food, the line of cars stretched for more than a mile and a half. By early afternoon of this cold December day, more than 2,000 residents had received food. That is 7 percent of the local population in a county where people drove 20 or 30 minutes to get there. Seven percent of the local population in 1 day, in one church, came to this food pantry for food. Just 8 years ago, that pantry served 17 families a month—17 families a month. One December day, 2,000 families, that is a crisis.

In the Los Angeles Times yesterday, a grateful recipient of scant food donations said: I eat anything they give me.

In the Virginia Pilot in southeast Virginia yesterday, a recipient admitted: What I get here lasts all month. I kind of stretch it.

Of the shortages at the food banks, Tim from Cleveland asked: How hard is it to give a can of tuna?

In a nation as wealthy as ours, no one who works hard for a lifetime—as most of these people who have gone to food banks do and have worked a lifetime to provide for their families, to get along, try to join the middle class—no one who works hard for a lifetime should ever have to make statements like those statements.

This is a national crisis. In a faltering economy, more people descend into crisis. It is inevitable. The need for economic stimulus goes hand in hand with the need for a caring community. Again, the economic stimulus package needs to stimulate the economy. It also needs, equally, maybe more importantly, to help those who have been victimized by this recession.

Our Nation has always been a caring community. More children are hungry today. More elderly Americans cannot pay their heating bills. More middle-class families now consider themselves among the working poor. Americans do not turn their backs on fellow Americans in need. As individuals, Americans do not; as a government, we should not.

The economic stimulus package should revive the economy and reaffirm our bonds with each other. This economic stimulus package is an opportunity to demonstrate our economic and moral strength. Let us take that opportunity. Let us act immediately to prevent more Americans from going to bed hungry.

The stimulus package needs to include food banks, food pantries, extension of unemployment compensation, and help for those elderly Americans who simply cannot pay their heating bills.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I wish to commend my friend and colleague from Ohio for addressing this issue on the challenges we are facing in terms of our economic situation here in the United States. The world is aware of this, as is anyone who watches the early morning programs. But most of all, we have been seeing this develop over a period of time, as the Senator has pointed out, and it is really shocking to me that it has really taken this long for the administration to come up and develop its own program.

I join with him in urging early action. We cannot delay. We cannot wait. The time is now on this issue. And I just thank him for telling us how it was out in the State of Ohio because the conditions he has described out in his State are very similar to the conditions in my State of Massachusetts. We will hear from many of our colleagues that they are feeling this as well. So we look forward to working with him and others here in the Senate and helping to fashion this program that is absolutely essential for the well-being of working families in this country.

I am always reminded, as the Senator is, that the American people who are so adversely affected did not do anything wrong. They have been working hard, playing by the rules, and trying to provide for their families. The responsibility to do something about it is right here with the administration and with the Congress. So many Americans' lives have been turned upside down, in many respects shattered. It adds a very special responsibility for all of us. So I thank him for his very useful and important contribution.

In recent weeks, the headlines have been filled with bad economic news. Two weeks ago, it was an alarming increase in the unemployment rate. Last week, it was rising prices for basic essentials such as food and gasoline. Week after week, there is more bad housing news. Foreclosures are skyrocketing. Bankruptcies are rising. Yesterday, the Washington Post discussed challenges facing the more than 1.3 million Americans who have been actively looking for a job for more than 6 months—for more than 6 months without success. It is a tragic tale. College-educated professionals and people who have worked for decades are now forced to drain their retirement accounts and rely on charity to make ends meet. It seems that every day there is new information showing that the economy is headed in the wrong direction, that no one will be spared.

These are not statistical trends or indicators. Every bad number reflects a real hardship in real people's lives. When food prices increase by 5 percent, that means average families will pay over $400 more next year to put meals on the table. When the unemployment rate rises 1.5 percent, it pushes a typical family's wages down $2,400. Each higher cost or lower paycheck adds up to big problems for working Americans. Parents are giving up time with their families to work longer hours or take a second job. Employees are struggling with credit card debt and skyrocketing interest rates. Young couples are losing their first homes because they cannot pay the mortgage, and parents are pulling their children out of college because they cannot pay the bills. For these families, a recession is not just part of the business cycle; it is a life-changing event from which they may never fully recover.

I have heard from many in Massachusetts who are struggling in these tough times. There is Teresa in Everett. She is a single mom with three children aged 10, 6, and 3. She is proud that she has worked her way out of welfare, but her life as a working mother is increasingly hard. Her bills are out of control, and each day she is faced with impossible decisions: Do I feed myself or feed my children? Can I turn on the heat or just put on an extra layer of clothing and try to get by? In Teresa's household, a $4 gallon of milk has become a luxury she cannot afford.

Teresa's family is not alone. A looming crisis is now facing tens of millions of American families. Economists across the spectrum, from former Treasury Secretary Larry Summers to Federal Reserve Chairman Ben Bernanke, and even President Bush himself, all agree that we are facing tough times to come and the Government must act.

But even more importantly than advice from these noted scholars is the clear message of the American people. They are struggling. They need our help now. They elected us to make their lives and their children's lives better, and now is the time.

We need a simple, effective plan to stimulate the economy and also put back in workers' pockets resources and money to give them the support they need to weather the storm. This plan should be built on one fundamental principle: People do not work for the economy; the economy should work for the people. If we want an economic recovery that works, if we want real opportunities and sustainable growth, that effort must start and end with working families.

Putting people first means targeting our stimulus efforts to meet three essential goals.

First, we must act quickly to provide immediate help for those in crisis. The declining economy may be a current issue in the newspapers, but working families have been suffering for some time; 7.7 million Americans are already unemployed. There have been almost 2 million foreclosure filings in the last year alone, including 225,000 last month. The number of families facing bankruptcy has risen by 40 percent in the past year. For these Americans, the recession is already here, and they need help now to get back on their feet.

Second, we must do the most for those who need help the most. Targeting families at the very bottom of the economic ladder is essential because it also provides the biggest economic boost. Every dollar a low-income household receives is spent on basic needs, putting money back into the local economy right away. In regions with many struggling families, such spending is critical to help keep entire communities afloat.

Finally, we must find solutions that will make a real difference in people's lives. It is not enough just to tinker at the margins. Our economic problems are getting worse every day, and we need a strong medicine to make things right.

There are a number of short-term steps we can take to achieve these goals and restore hope and opportunity to families across the country. They are simple. They build on existing programs. They are effective. We should pass them, and we should pass them now.

For workers who are struggling to find a job, we must support them in the difficult process of finding work. It becomes harder and harder to find a good job in today's economy. The Nation is enduring profound changes as we adapt to the global economy. Entire industries are disappearing, leaving workers and communities devastated in their wake. Madam President, 1.3 million workers have been getting up early every morning, day in and day out, looking for a job for more than 6 months. That number will only rise as the recession deepens. Just last week, Goldman Sachs economists predicted that the unemployment rate would reach 6.5 percent by the beginning of 2009 compared to 5 percent today.

This is a dual challenge. We now have projections about what we are going to have in terms of unemployment. No matter what we do in terms of stimulating the economy—we have to stimulate the economy—we also have to be mindful that we are going to have significant unemployment even in the outyear of 2009 as Goldman Sachs has predicted. We have both challenges, the economy and the fact that people are going to be unemployed.

To help these unemployed men and women weather the storm we need to extend unemployment benefits and expand access to benefits. As workers, they have paid into the system and they deserve help when they need it. We should also provide transitional health care assistance. People who receive unemployment compensation have paid into the fund. The problem now is many of them, even though they paid into the fund, are unable to benefit from it. That is wrong. We should address that. We have legislation to do so. It passed the House of Representatives, and we should pass it as part of a stimulus program at the present time.

Most importantly, we should do more to help unemployed workers find good jobs they are seeking. We have open jobs, 93,000 in Massachusetts alone. We certainly have jobs that are available, and we have more than 178,000 unemployed workers. So we have the jobs that are available, and we have the unemployed workers. What is missing? Training programs. How many applicants do we have for every training program? We have 21 applicants for every training program. We have good jobs with good benefits, and we have the people who want them. The only ingredient missing is training, and these workers want the training. They will sacrifice for training. But they haven't got it because we have cut back on training programs in recent years. We ought to be able to address those issues, and we ought to do it now.

It is not just those who have lost their jobs and are facing a crisis. Millions more families are living on the brink of disaster because they are struggling to pay bills. Since President Bush took office, the cost of health insurance has risen 38 percent. Housing prices are up 39 percent. A tank of gas is up 78 percent; tuition, 43 percent; and wages are stagnant, up 6 percent. This is the pressure families are feeling today, a sense of insecurity.

Security is an issue that is of major importance and consequence to families. They are concerned about security overseas. They are concerned about homeland security. But they are also concerned about job security and health security and education security. They are also concerned about energy security. They are concerned about their long-term security, what is going to happen to pensions, as they see the safety net for pensions increasingly fragmented. They are concerned about unemployment insurance security as they have seen that safety net fragment. They are deeply concerned. They are all worried deeply about it.

It is interesting. I don't know how many times during the course of the debate on the stimulus that we will take a moment and think of what is the cost of the anxiety that these families have, when they are worried primarily about their children or grandparents. That doesn't appear on the bottom line of any sheet we will have on the floor of the Senate, but it is out there and being felt now, and it is very real. We ought to understand that—real anxiety, real frustration, real suffering, real worry every day, every night, primarily by parents as they are concerned about their children. They worry about their loved ones and their families, immediate family, and less about themselves. They worry about others. We have the ability to deal with that, and we must.

We need a boost in basic support programs to help working families cope with the relentless pressure of everyday life during this time. This means expanding home heating assistance. A typical household may have to spend as much as $3,000 on heating oil this winter, probably closer to $4,000 in Massachusetts. Fuel assistance will cover less than a third of these costs. Of the 35 million households eligible for fuel assistance nationwide, only 5 million receive such benefits. Six of seven families in need receive no help at all because the States run out of funds.

Last week, the White House released $450 million in emergency assistance to States across the Nation, including $27 million for Massachusetts. The reality is, when oil prices are surging past $3.30 per gallon, and households will need at least 800 gallons of heating oil this winter, it is just not enough.

Bob Coard of Action for Boston Community Development, one of the largest community action agencies in the Northeast, says the emergency funds will barely cover enough to make a 100-gallon delivery to ABCD clients, and the 100-gallon delivery will cost about $300 and will provide a family with heat for about 2 to 3 weeks. Talk about something that will have a direct impact. A week ago Massachusetts was notified that it was going to receive approximately $30 million, and they were, within a 2-week period, able to get the oil tankers up to find those who are eligible for that program to deliver 100 gallons of fuel oil to needy families. That will only last 2 weeks. It is out there. We know what the need is. We know what these individuals suffer. So we can do things that can have an immediate impact. Certainly this is something to which we should be attentive.

The people who are receiving this fuel assistance are in danger of this perfect storm that we refer to in New England where they have extraordinary increases in prices generally. One part of the storm is an increase in the cost of fuel oil to heat their homes. A second part is their ability to afford to pay their mortgage. If they cannot pay the mortgage, this is what happens. They make a judgment about whether they are going to pay the fuel or pay the mortgage. With children in the picture, they pay their fuel and they end up losing their home. So the fact that they don't get maybe 100 gallons, 200 gallons, 300 gallons of oil means they lose their home.

The cost in Massachusetts of providing services to a homeless family can be thousands of dollars a year. You can provide the oil for a fraction of that and keep people in their homes.

These are the kinds of things that make a difference. We should give focus and attention to them.

In our hearing this last week, I heard from Margaret Gilliam who takes care of her grandchildren in Dorchester and has already spent more on heating oil this heating season than she did all of last year. We still have many weeks of cold weather ahead, and she wonders what is going to happen to her grandchildren and to her home. Diane Colby, a single mother of two in Lynn, MA, keeps the thermostat at only 62 degrees to stretch out the heating oil as long as possible. She has to sit down and decide which bills get paid and which don't. Otherwise she can't afford to keep the heat on. We must ensure that these families have the help they need through the winter. This is part of the challenge we are facing.

In the proposals we have had from the President, we find that he proposes a tax break and a stimulus program that would completely leave out the poorest Americans. That is bad policy. Not only are low-income families the ones who suffer most in a recession, helping them is the best way to be certain that any stimulus goes directly into the economy and benefits our country the most. We can't keep repeating the mistakes of the past. Any tax rebate we pass now should be for everyone so that everyone can get back on their feet. The President's tax cuts for business are ill-advised. Past experience shows that such corporate tax breaks do not provide an effective stimulus. The problem with our economy today is a lack of demand, not of capacity. Businesses will not produce more until they know that customers are ready to buy. That is extremely important.

We heard at our Joint Economic Committee hearing economists talk about the lack of demand, not a lack of capacity. Since there is a lack of demand, it doesn't make a lot of sense to increase capacity if there is not demand for it. Yet that is what the administration is attempting to do.

Personal tax cuts targeting middle- and low-income families and funding boosts for programs such as unemployment insurance and food stamps are a better stimulus than business tax cuts because they encourage consumers to start spending. The economy is at a crossroads, and we must act carefully to choose the right path for the future. I am confident we can do that. I am certain we must do it to get America back on track.

Finally, I want to review a few of the charts I have that spell out exactly where we are globally on this issue. Americans are deeply anxious about the economy. In a survey from just two weeks ago, Madam President, 61 percent of Americans say the condition of the economy is bad; one in five think things are very bad. This is an indication of the attitude of the American people. Here is one of the reasons.

We see a significant increase in the unemployment rate in December, going to 5 percent. Among unemployed workers, 17.5 percent are long-term unemployed. If you look at 2001 as we approached the last recession, it was only 11 percent. Now it is 17.5 percent, up 55 percent. These are individuals who are out there, workers who want a job and have been spending month after month after month looking for one, unable to get a job. That has a devastating impact, particularly when you terminate the unemployment compensation for them which these individuals should be eligible to receive and which they have paid into.

This shows the prediction from economists that unemployment will skyrocket next year. We heard this in testimony in the Joint Economic Committee hearing last week. Assuming we have a stimulus program, they say the economy can improve, but even with the economy improving, we are going to have a continued increase in the numbers of unemployed. That is something we have to be aware of.

We still have job openings that are here, but nearly 8 million unemployed workers competing for 4 million jobs. It is a real problem. Not being able to get these jobs is a result of administration cuts to training programs all of these years. This is a pretty good indicator of what happens with the limitations.

Americans cannot access job training programs. Opportunities are limited for workers to improve their skills. In Massachusetts alone, as I mentioned, for every available slot in a job training program, there are 21 workers on a waiting list. I have in the Chamber a picture of workers waiting on a waiting list. These people want to work. They want to provide for their families. They have the skills, the training programs to be able to get the job done, but they cannot afford that. We have had training programs, the kind the administration has cut back. Last year, it was close to half a billion dollars.

This chart shows what has been happening with the unemployment rate. It has been going steadily up. High unemployment drives down wages. A 1.5-percent increase in the unemployment rate would decrease the average family's income by $2,400 because of the downward pressure it puts on wages. So for every family—we know from Goldman Sachs; this is not our estimate, we have it from financial institutions—economic indicators indicate we are still going to have high unemployment.

What that means is a real reduction for average working families in their purchasing power by $2,400. That is what is going on.

We have seen what is happening as to the kinds of products that families are used to purchasing. The price of food is rising far faster than the rate of inflation. We have milk going up 16 percent, eggs going up 78 percent, and beef going up some 13 percent.

In our part of the country, still, about 75 percent of all the homes are heated with home heating oil. Look what has happened. There has been a 40-percent increase in the cost of home heating oil since last year. And a great many of our people in my part of the country who own their homes are living on fixed incomes. They are getting this kind of increase. Social Security, for the average person, went up only 2.3 percent from last year. But here we have a 40-percent increase in the cost of home heating oil, and it has been a cold winter.

So these charts indicate, in different ways, how the average family is facing more and more difficulties. Too many middle-class families could not pay the essential expenses in the event of a job loss or other financial hardship. Seventy-seven percent of middle-class families do not have enough assets to pay the essential expenses for 3 months.

What is happening is many people are relying on their credit cards to do it, and then they are unable to meet their ends with their credit cards. That directly affects their credit standing for the rest of their lives—under the last bankruptcy bill we passed here, which was such an unfortunate action that we took in the Senate.

We find out parents are listing credit cards in the names of their children—young children—in order to be able to heat their homes. It is affecting so many hard-working Americans who are facing that whammy—the fact they are in danger of losing their homes because of the mortgage challenge. They cannot afford heating oil, and then they find out, when they resort to using credit cards, they lose all of their potential for credit for years to come.

This chart is a reflection of what is happening with people losing their homes. Foreclosures have gone up 181 percent from 2005. Millions of American families face losing their homes. Make no mistake about it, many who lose their homes have in the past paid their mortgages each month, and yet now they lose their home. We have to ask: What are we going to do about it?

Just a final two points I will make. There has been a 40-percent increase in bankruptcies. This is a result of the kind of economic squeeze these families have been under. There has been a 40-percent increase in bankruptcies. With the way that last bankruptcy act was enacted, they will find out, once the hooks get into these families, they will never get free from them. Families are going to be indebted for a very considerable period of time. That is now happening to working Americans.

The final chart I will put up is that in looking at the stimulus program we ought to look at what gets the biggest bang for the buck. Targeted stimulus programs deliver far more bang for the buck. As to unemployment benefits, for every $1 we invest, there is $1.73 in economic growth; for aid to the States, $1.24; for income taxes, it is only 59 cents. These are the areas the administration is talking about: business write-offs, 24 cents; capital gains tax cuts, 9 cents.

If we are going to pass a stimulus package—which we should do—let's look at the areas that will have the greatest impact, the greatest stimulus that will help the working families of this country in the most meaningful way. That is what we should do. That is what should be the first order of business in the Senate. I hope we will get about the business of helping working families in America.

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

The PRESIDING OFFICER (Mr. CARDIN). The clerk will call the roll of the Senate.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. DORGAN. Mr. President, I ask unanimous consent that the pending amendment be set aside.

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

AMENDMENT NO. 3899

(Purpose: To provide a complete substitute.)

Mr. DORGAN. Mr. President, I have a substitute at the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from North Dakota [Mr. DORGAN] for himself, Ms. MURKOWSKI, Mr. BAUCUS, Mr. KENNEDY, Mr. SMITH, Mr. NELSON of Nebraska, and Mr. SALAZAR, proposes an amendment numbered 3899.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. DORGAN. Mr. President, I ask unanimous consent that the amendments previously considered be conformed to the substitute I have just offered.

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

Mr. DORGAN. Mr. President, I suggest the absence of a quorum.

I withhold that suggestion.

The PRESIDING OFFICER. The assistant majority leader is recognized.

Mr. DURBIN. Mr. President, I ask unanimous consent to speak as in morning business for 5 minutes.

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

(The remarks of Mr. DURBIN are printed in today's RECORD under ''Morning Business.'')

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. DORGAN. Mr. President, we have had a lot of discussion and debate today about the Indian Health Care Improvement Act. We, on behalf of myself and Senator MURKOWSKI, sent the substitute to the desk. The substitute is something we worked on that amends and changes somewhat what we had originally moved out of the committee. We have refined it, improved it, and changed it a bit. The substitute was agreed to by Senator MURKOWSKI and myself and other Senators with whom we have worked. So we have made some progress by laying down the substitute which perfects this bill. We have a number of amendments pending.

What I would ask—and so would Senator MURKOWSKI—is if there are others who have amendments to this bill, they come to the floor and offer them. We want to finish this piece of legislation. It is not as if we haven't had a lot of discussion and debate. We have pretty much filled the time today. But we do want additional amendments to be offered. What we would like to see is if those Senators who have amendments would contact us, we could schedule them and hopefully we can get some time agreements, so when we finish this evening and come back on this bill, we could get a list of amendments, work through those amendments and finish the bill and send it along to the House. Because there is an urgency here.

There are some things we do that are not particularly urgent. I understand that. If anyone thinks the issue of Indian health care is not urgent, I urge them to go to the nearest Indian reservation and have a visit about what is happening with respect to the Indian Health Service. I know there are a lot of good people working in the Indian Health Service, but I am telling you, go sit and listen for awhile, listen to a discussion about what happens when you ration health care, when health care is not a right and not only not a right but when health care is absolutely rationed. There are people dying. There are people living in pain. There are people who don't have access to any kind of health care facility. There are people who are having emergencies at 5 in the afternoon, when their local clinic closed their doors at 4, and they are 100 miles from the nearest hospital. That is what is happening on Indian reservations across this country.

We have a responsibility, a trust responsibility to provide for that health care. The Congress, this country has not owned up to that responsibility, and we must. That is why we have brought this bill to the floor of the

Senate, and I am hoping very much for the cooperation of my colleagues. Let's complete the amendments, raise them with us, let us work with you on getting them up and getting votes on them so we can at least indicate our support to do what we are required to do as American citizens: honor our treaties, meet our trust responsibilities, and keep the promises we have made to the first Americans.

UNANIMOUS CONSENT AGREEMENT—H.R. 4986

Mr. DORGAN. Mr. President, I ask unanimous consent that at 5:30 p.m. today, the Senate proceed to the immediate consideration of H.R. 4986, the Department of Defense authorization, with no amendments in order to the bill; that the bill be read a third time, and without further action, the Senate proceed to vote on passage; that upon passage, the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DORGAN. Mr. President, I yield the floor and I make a point of order that a quorum is not present.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

NATIONAL DEFENSE AUTHORIZATION ACT

Mr. LEVIN. Mr. President, in a few moments we are going to vote on the Defense Authorization Act for fiscal year 2008.

The bill before us today is the same bill we passed by a 90-to-3 vote a little more than a month ago, except for minor changes.

This bill will provide essential pay and benefits for our men and women in uniform. It includes a 3.5-percent pay raise for the troops.

It includes the Wounded Warrior Act, the greatest reform in the law relative to medical care for our troops in more than a decade. It will address the substandard living conditions, poor outpatient care and bureaucratic roadblocks and delays faced by injured soldiers. These provisions will dramatically improve the management of medical care, disability evaluations, personnel actions, and the quality of life for service members recovering from illness or injuries incurred while performing their military duties and begin the process of fundamental reform of DOD and VA disability evaluation systems.

The Wounded Warrior Act will require the Secretary of Defense and the Secretary of Veterans Affairs to work together to develop a comprehensive policy on the care, management, and transition of severely injured service members, including Active Duty, National Guard, and Reserve members, from the military to the Veterans Administration or to civilian life. It will require the use of a single medical examination where appropriate, and require and fund the establishment of centers of excellence for the signature wounds of the wars in Iraq and Afghanistan—post-traumatic stress disorder and traumatic brain injury.

To improve the disability evaluation system, the bill will require the military departments to use VA standards when making disability determinations, authorizing deviation from these standards only when it will result in a higher disability rating for the service member, and will require the services to take into account all medical conditions that render a member unfit for duty.

The bill will also increase the severance pay for military personnel who are separated for medical disability with a disability rating of less than 30 percent and will eliminate the requirement that this severance pay be deducted from VA disability compensation for disabilities incurred in a combat zone or combat-related operation.

The bill also includes essential management reforms for the Department of Defense, including the Acquisition Improvement and Accountability Act of 2007. Some of the reforms included are: establishment of a defense acquisition workforce development fund to ensure that DOD has the people and the skills needed to effectively manage its contracts; strengthening of statutory protections for contractor employees who blow the whistle on waste, fraud, and abuse in DOD contracts; and tightening of the rules for DOD acquisition of major weapons systems and subsystems, components and spare parts to reduce the risk of contract overpricing, cost overruns, and failure to meet contract schedules and performance requirements. These and other provisions should go a long way toward addressing the contracting waste, fraud and abuse that we have seen altogether too frequently in recent years.

Our legislation will also address a major failure in Iraq—the failure to exercise control over private security contractors. It will require for the first time that private security contractors hired by the State Department and other Federal agencies to work in a war zone comply with directives and orders issued by our military commanders as well as with DOD regulations.

On December 17, 2007, we sent the defense authorization act to the President for his signature. The following weekend, the White House staff notified us that they had identified a problem with one provision that would lead the President to veto the bill. While the administration had previously expressed concerns about this provision, no administration official had ever indicated that the President would consider a veto. Quite the opposite, this provision was not on the list of potential veto-causing problems.

I remain disappointed by the administration's failure to work with us to address this provision until after the bill had passed both Houses of Congress and was sent to the President for signature. It does not serve anybody's interest when we fail to address issues like this in a timely manner. The veto of the National Defense Authorization Act sent the wrong message to our soldiers, sailors, airmen and marines at a time when many of them are risking their lives on a daily basis in Iraq, Afghanistan, and elsewhere.

I am pleased that we have been able to work out language to address the administration's concerns on a bicameral and bipartisan basis. The bill that is before us today contains modifications that have been agreed upon by the White House and by the bipartisan leadership of the House and Senate Armed Services Committee. I understand that these changes are also acceptable to Senator Lautenberg and other Members who worked with him to put together the provision in the earlier bill.

Let me briefly explain the White House's problem, and how we have addressed it.

Section 1083 of the bill clarifies the law that permits U.S. nationals and members of the U.S. Armed Forces who are victims of terrorist acts to sue state sponsors of terrorism for damages resulting from terrorist acts in the U.S. courts. The provision also strengthens mechanisms to ensure that victims of terrorism can collect on their judgments against such State sponsors of terrorism. U.S. courts have previously entered such judgments against Iran, Libya, and Saddam Hussein's Iraq.

After the bill was passed and sent to the President for signature, the administration informed us that Iraq currently has more than $25 billion of assets in this country that could be tied up in litigation if section 1083 were enacted into law and that such restrictions on Iraq's funds could take months to lift. The White House stated that restrictions on Iraqi funds would interfere with political and economic progress in Iraq and undermine our relations with Iraq.

We have addressed these concerns with new language which authorizes the President to waive the applicability of section 1083 to Iraq, if he determines that a waiver is in the national security interest of the United States; that the waiver will promote Iraqi reconstruction, the consolidation of democracy in Iraq, and U.S. relations with Iraq; and that Iraq continues to be a reliable ally of the United States and a partner in combating international terrorism.

The revised language also expresses the sense of Congress that the President, acting through the Secretary of State, should work with the Government of Iraq on a state-to-state basis to ensure compensation for any meritorious claims based on terrorist acts