The Senate met at 9:31 a.m. and was called to order by the Honorable Mark R. Warner, a Senator from the Commonwealth of Virginia.

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

Let us pray.

Our Father, we bow in Your sacred presence to acknowledge our need of You. We can do without many things, but without You we can’t live.

Meet the needs of the Members of this legislative body. When sorrow and shadows fall on their path, fill them with Your joy and light. When their health fails, be for them the great physician. Lord, we also ask You to protect their loved ones with the shield of Your favor. Give our lawmakers courage for hard times and strength for difficult places. We pray in Your loving Name. Amen.

PLEDGE OF ALLEGIANCE
The Honorable Mark R. Warner led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE
The Presiding Officer. The clerk will please read a communication to the Senate from the President pro tempore (Mr. Byrd).

The assistant legislative clerk read the following letter:

U.S. Senate, President pro tempore, Washington, DC, December 4, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable Mark R. Warner, a Senator from the Commonwealth of Virginia, to perform the duties of the Chair.

Robert C. Byrd, President pro tempore.

Mr. Warner thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER
The Acting President pro tempore. The majority leader is recognized.

SCHEDULE
Mr. Reid. Mr. President, following leader remarks, the Senate will resume consideration of the health care bill. The time until 11:30 a.m. is equally divided and controlled between the leaders or their designees. The majority will control the first half and the Republicans the second half.

We have a number of votes we are going to try to arrange this afternoon. We will let all Senators know as soon as we have this worked out, but there will be some votes today and tomorrow.

HEALTH CARE REFORM
Mr. Reid. Mr. President, the amendment process continues to crawl forward, and this historic health reform bill continues to evolve and improve. This is a good bill. It saves lives, saves money, and saves Medicare. It makes health insurance more affordable, makes health insurance companies more accountable, and makes our economy stronger. The Democrats know we can make it even better. This is happening because of the dedicated hard work from throughout the Democratic caucus—from veteran Senators and newer Senators, by the hands of men and women from diverse parts of the country and good public servants from all points of the political spectrum.

Senator Mikulski of Maryland, who for decades has been a champion for women’s health, made it better by making sure women can get the mammograms, the checkups and preventive care they need to stay healthy and get them at no cost.

Senator Bennet of Colorado, who has served skillfully in this body for less than a year, made it better by reaffirming our commitment to Medicare. He made it better by ensuring seniors get the care they need and the quality of life they deserve.

That positive trend will continue today. Senator Whitehouse of Rhode Island, who came to Congress with a class of Senators elected with a strong mandate to change the way Washington works, has proposed an amendment based on common sense and accountability. It says the money dedicated to the health care of American seniors and of people with disabilities should be used only for those precise purposes.

This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Unfortunately, Senate Republicans are less interested in solving problems than they are in creating them. The day before this floor debate began, the assistant Republican leader—the junior Senator from Arizona—said: “There is no way to fix this bill.” Of course, that is absolutely totally wrong.

All Senators know there is a reliable way to improve legislation—to improve this bill. It has been in use for 220 years. It is called the legislative process. It is called doing our job.

As a Senate to continue to improve, I, once again, remind my colleagues not to lose sight of the bigger picture. As we delve into the details and debate the fine print, let us not forget why we are here. Our goal remains the same. It was the day we began this debate many months ago. It remains the same as it was a year and a half ago, when Senate Finance Committee chairman MAX BAUCUS first held a series of hearings that led to the legislation that is now before us.

Our goal remains the same as it was last November when the American people called in a loud and clear voice for change. It remains the same as it did 51 years ago, when Senator Ted Kennedy called it shameful that “in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.”

It remains the same as it did the day President Truman sounded a call to action to ensure that American families are protected from what he called “the economic effects of sickness.” That was more than 64 years ago, and more than half of today’s Senators weren’t even born then. That constant goal has been and remains this: We must make it possible for every American—each and every American—to afford to live a healthy life.

Each moment in this fight is historic. Each bill to make health care decisions in the hands of the people has ever come this far. But the most historic days of the journey lie ahead. We can only seize that opportunity if this debate is about facts, not about fear.

I remind my colleagues that if we are to truly help the American people and the American economy, if we are to sincerely do the work our neighbors sent us to do, if we are to leave our children and grandchildren a better inheritance than a deep deficit and a broken health care system—if we are to do any of these things—we must work together and not against each other. We must work as partners, not as partisans.

This is not the first time I have asked my Republican friends to abandon their shortsighted strategy to bring the Senate to a screeching halt; for example, issuing an informational guide on how to stop and slow things. That doesn’t work. We need a strategy that says we can work on some things done. I have had a couple good conversations the last few days with some of my colleagues on the other side of the aisle. I hope we can move forward. This is a bill that doesn’t look at a person who is sick or hurt or afraid as being a Democrat or a Republican or an Independent. They are Americans. They are from Virginia, Montana, Nevada and from all over America and they are people who are calling upon us to do the right thing.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, we had a very clarifying vote on the Senate floor about the direction of our friends on the other side with regard to our health care system. Yesterday, all but two of them voted to preserve nearly $72 trillion in cuts to Medicare, the health program for our seniors. In the runup to that vote, they said these cuts were not cuts and that Medicare Advantage in particular is not a part of Medicare, arguments plainly contradicted by the text of the bill itself, by the Department of Health and Human Services, by the independent Congressional Budget Office, and by the experience of seniors themselves.

Seniors do not want Senators fooling with Medicare. Let me say that again. Seniors do not want Senators fooling with Medicare. They want us to fix it, to strengthen it, to preserve it for future generations—not raid it like a giant piggy bank in order to create some entirely new government program.

Yesterday’s vote was particularly distressing for the nearly 11 million seniors on Medicare Advantage. So today Members will have an opportunity to undo the damage they voted to do to this program. With yesterday’s vote, proponents of this measure authorized $120 billion in cuts to Medicare Advantage and in the process they moved to violate the President’s pledge that seniors who like the plans they have can keep them. The President has said seniors who like the plans they have can keep them—because you can’t cut $120 billion from a benefits program, obviously, without cutting benefits. The Congressional Budget Office has been crystal clear on this matter. When asked about the effect these cuts would have on Medicare Advantage, the Director of CBO was unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill.

One Democrat last night was explicit. He admitted that after yesterday’s votes, Democrats will not be able to say that “if you like what you have you can keep it.” This is one of our Democrat colleagues yesterday saying: “If you like what you have you can keep it” can no longer be said.

He went on to say “that basic commitment that a lot of us around here have made will be called into question.” I think that is highly likely.

Our friends have a couple of choices here today. They can reaffirm their plan to cut benefits for nearly one-fourth of all seniors enrolled in Medicare, they can admit that the President’s pledge about keeping the plan you like no longer applies, or they can reverse part of yesterday’s vote later today by voting with Republicans to restore those cuts to Medicare Advantage.

I yield the floor.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will recess on H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute. 

Whitehouse amendment No. 2670 (to amendment No. 2786), to promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this act.

Hatch motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are beginning our fifth day of consideration on the health reform bill. We will be in a period of debate only until about 11:30 a.m. Pending now is the
amendment by the Senator from Rhode Island, Mr. WHITEHOUSE, on fiscal responsibility. Also pending is a motion to commit by the Senator from Utah on Medicare Advantage. It would be my hope that the Senate will vote on these matters today.

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

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

The assistant legislative clerk proceeded to call the roll.

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

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

Under the previous order, the time until 11:30 a.m. will be for debate only with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first portion of time.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, experts and economists of every political stripe agree that preserving America’s long-term fiscal security means reforming the way we provide and pay for health care. Health care spending makes up one-sixth of the U.S. economy. Future generations can expect the burden of insurmountable debt if we fail to act.

The fiscal challenges we may face in years to come pale in comparison to the threat of uncontrolled Federal health care spending. The chart behind me essentially shows that. The chart shows the percentage annual growth rates beginning in 2004. The red is the economy, the blue is health care costs. Clearly, over time, especially as the economy dipped during this great recession, the gap between economic growth and health care spending has widened. And it is that in future years they will widen more and more. As you can see out to 2018, the total economy is projected. Near 2018 the economy is above 4 percent and health care spending is 7 or 8 percent.

Doing nothing means health care spending continues to grow faster than our economy. That is what that chart shows quite dramatically. Doing nothing means entitlement spending more than doubles by the year 2050. That is taking one-fifth of our gross domestic product.

But it is not simply the Federal budget on the line, it is the family budget too. Incredibly, in total we are spending 80 times as much on health care today as we did five decades ago—80 times more on health care today than we did five decades ago. Now family budgets are breaking under the strain—already. That is going to get worse if we do nothing. The cost of the average family health care plan will reach $11,000 by the year 2016. That is not too many years away from now. This represents an 84-percent increase over 2008 premium levels. That means, if we do nothing, in fewer than 10 years most families would have to dedicate half of their household budget to health insurance. For years we have heard the warnings from Federal budget experts. Now we are hearing every day from folks back home who simply cannot afford the care they need.

We have an obligation to act. Now we have an opportunity to act. The country’s leading economists and Federal budget experts laid out strategies and options for getting costs under control. We have taken their recommendations to heart. There is a lot of agreement among those who study these issues of what we must do. Now we have a bill that does what they suggest. It also achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, makes a serious dent in our Federal deficit.

This chart behind me represents what 2 weeks ago the Congressional Budget Office and Joint Committee on Taxation confirmed in no uncertain terms. Nolts back home will be asking, ‘Why believe without his leadership, we would not be where we are today in our effort to reform health care. I congratulate him on the superb effort he has made.

I want to spend a few minutes talking about health care reform both as it affects the country but also as it affects my home State of New Mexico. First, I would like to discuss the context for this health reform bill, and that is the very serious problem we face in the country and in our State. Now we are hearing every day from folks back home who simply want to know about what would happen if it doesn’t pass.

No honest assessment of this bill. It protects and even increases Medicare benefits for seniors. It achieves near universal coverage in less than 10 years. That means it achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, makes a serious dent in our Federal deficit.

I yield 15 minutes to the Senator from New Mexico.

Mr. BINGAMAN. Mr. President, let me thank Senator BAUCUS for his leadership on this issue. I have mentioned to many times in many settings that I believe without his leadership, we would not be where we are today in our effort to reform health care. I congratulate him on the superb effort he has made.

I want to spend a few minutes talking about health care reform both as it affects the country but also as it affects my home State of New Mexico. First, I would like to discuss the context for this health reform bill, and that is the very serious problem we face in the country and in our State. Now we are hearing every day from folks back home who simply want to know about what would happen if it doesn’t pass.

No honest assessment of this bill. It protects and even increases Medicare benefits for seniors. It achieves near universal coverage in less than 10 years. That means it achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, makes a serious dent in our Federal deficit.

In addition to reducing the Federal deficit, in the first decade, the CBO also tells us that the bill decreases the deficit by a much greater amount, by $650 billion, in the second decade.

According to the CBO, this bill also slows the growth of Medicare costs, which has been a principal goal in our Medicare debate since day one. Medicare spending would grow 6 percent annually instead of 8 percent annually. In other words, Medicare would continue to grow but, unlike today, it will grow at a sustained rate. Of course, no projections, even from the Congressional Budget Office, can be certain. We can safely say this bill will put us on the right track. We can safely say this bill is better than doing nothing.

Krugman of Princeton University. He talks about how some Senators have concerns about going ahead with this health care reform bill because of what it might cost. He makes the point:

But if they’re really concerned with fiscal responsibility, they shouldn’t be worried about what would happen if health reform passed. They should, instead, be worried about what would happen if it doesn’t pass. For America can’t get control of its budget without controlling health care costs—and this is our best chance to deal with these costs in a rational way.

I ask unanimous consent that the full column from the New York Times...
of this morning be printed in the Record following my remarks.

The ACTING PRESIDENT pro tem.

Without objection, it is so ordered.

(See exhibit 1.)

Mr. BINGAMAN. As this chart demonstrates, according to the Congressional Budget Office, if we don’t act to deal with the growth in health care costs, Federal spending on Medicare and Medicaid combined will grow from 5 percent of GDP today to almost 10 percent by 2035. By 2080, the government would be spending almost as much as a share of the economy on just its two major health care programs as it has spent on all of its programs and services in recent years.

Let me put up another chart that demonstrates that most of this increase in cost is not the result of our aging population. We do have an aging population; that does add to the cost of health care because as people get older they tend to need more health care. The dark blue shows the increase expected in health care costs by virtue of aging. But the lighter blue talks about the effect of excess cost growth that is not tied to aging, that the growth in health care cost is out of control in our current system.

This spending is unsustainable. It has led the Congressional Budget Office to say:

Slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for fiscal policy.

Moreover, across the country, premiums continue to increase. They are becoming more and more unaffordable for individuals and for businesses. I hear on a regular basis when I go around New Mexico—and I am sure all my colleagues hear from their constituents as they travel in their States—that people cannot continue to pay more and more each year for their health care coverage. According to an August report by the Commonwealth Fund, nationally, family premiums for employer-sponsored health insurance increased 119 percent between 1999 and 2008. If cost growth continues on its current course, those premiums could increase another 94 percent to an average of $23,842 per family by 2020. I am not sure what the circumstance is in many States, but I know in New Mexico there are many families who cannot afford to pay $23,800 in health care premiums.

Nowhere is the unsustainable growth felt more acutely than in my home State. Without health reform, in my State we are projected to experience the greatest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico was about $6,000 in the year 2000. By 2006, this rate had almost doubled, or the cost had almost doubled to $11,000. By 2016, the amount is expected to rise to almost $28,000. In addition, health insurance premiums in New Mexico make up a larger percentage of New Mexico’s income, the income of the average New Mexico family, than almost all other States. We are paying 31.18 percent. Over 31 percent of the average income of a family in New Mexico is going to pay for health care. This is expected to grow to over 50 percent if we do not reform our health care system.

It is important to highlight that the higher spending on health care in the United States does not necessarily prolong lives. I hear a lot of speeches about how we have the greatest health care system in the world. We are the envy of the world. People would just love to have access to our health care system. This chart illustrates that in 2000, the United States spent more on health care than any other country in the world, an average of $4,500 per person. That was in 2000. Switzerland was the second highest at $3,300, substantially less. Essentially, its cost per person was 71 percent of what it was in the United States during that year. Nevertheless, the life expectancy comes out at 27th in the world. Our life expectancy average is 77 years. Many countries, 26 to be exact, achieve higher life expectancy rates with significantly lower spending on health care.

Data from the McKinsey Global Institute clearly indicates there is a considerable level of waste in our current system. McKinsey estimates that the United States spends nearly $3 trillion in a similarly situated nations. Of this, about $224 billion in excess costs are found in hospital care. About $173 billion are found in outpatient care. Together these account for more than 80 percent of U.S. spending above the levels of other nations.

Here is one other chart. This is one I have used before on the Senate floor. Not surprisingly, as costs and inefficiencies continue to build, access to health care becomes more difficult for middle- and lower-income Americans. This chart indicates the rate of uninsurance throughout the country. First, on the left-hand side is the year 2000; on the right-hand side is 2008. We can see the dark blue States are States where 23 percent or more of the population ages 18 to 64 are uninsured. Back in the year 2000, New Mexico and Texas were the only two States where the rate of uninsurance exceeded 23 percent. By 2008 the rate of uninsurance exceeds 23 percent for many of the States, particularly across the southern part of the country.

We have a very serious problem that needs addressing. It is clear that the U.S. health care system is falling many Americans. The situation is becoming more and more urgent. According to a study published by the Harvard Medical School in August, medical costs have led to almost two-thirds of the bankruptcies in this country. More than 137,000 people in this country died between 2000 and 2006 because they lacked health insurance. Two-thirds of these people in 2006. Clearly, the need for national health reform has never been so great.

The Patient Protection and Affordable Care Act, the legislation we are debating, introduced by Senator Rm and others a few weeks ago, includes the key reforms we have come up with and that the experts have come up with, aimed at addressing these very serious problems, while protecting the strength of our health system that are working today.

First, this bill includes long-overdue reforms to increase the efficiency and quality of the health care system while reducing overall costs. By 2016, the legislation includes payment reforms that I have championed to shift from a fee-for-service payment system to a bundled payment system. This will reshape our health care reimbursement system to reward better care and not simply more care as it currently does today.

Second, it includes a broad new framework to ensure that all Americans have access to affordable health care. This includes creation of a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable.

Finally, these new health insurance exchanges will help improve choices by allowing families and businesses to compare insurance plans on the basis of quality and performance, not just price, to put families, rather than the insurance companies or the government bureaucrats, in charge of health care. It helps people to decide which quality, affordable insurance option is right for them.

The Congressional Budget Office, which is cited here—quite frankly, I notice that the Congressional Budget Office is cited by both Democrats and the Republicans in this debate, and they have a credit to their name, are seen as nonpartisan, and they are nonpartisan. I congratulate Doug Elmendorf for the good work CBO has been doing in support of our efforts to come to the right answer on health care reform. If the CBO forecasts that this legislation would not add to the deficit.

As the chart Senator BAUCUS had a few minutes ago clearly indicates, the deficit would be reduced in the first 10 years by $130 billion. It would be reduced in the second 10 years, going up to 2029, by something over $600 billion.

Let me also point out the contrast. We are talking about a bill which the
Congressional Budget Office says will reduce the size of the deficit in future decades. I can remember a couple Congresses ago when we had a debate on adding subpart D to Medicare, Part D to Medicare. There are many on the floor who are concerned about cost today. I am sorry to say in my speeches—who were very anxious to add that legislation to Medicare, adding another $500 billion. That was estimated by the CBO at that time: another $500 billion over a 10-year period to the Medicare was hearing.

The efforts we are making in this legislation to bring under control the cost growth in Medicare is essential if we are going to keep Medicare solvent in the future, and part of the solvency problem Medicare has in the future, frankly, is related to what we did in subpart D.

On the subject of premium cost, CBO has also found that in the individual market, the amount that subsidized enrollees for non-group insurance would be roughly 56 percent to 59 percent lower, on average, than the premiums charged in the individual market under current law. Among enrollees in the individual market who would not purchase health insurance, average premiums would increase by less than 10 to 13 percent. This legislation would have a smaller effect on premiums for employment-based coverage. Its greatest impact would be on smaller employers and their employees, CBO predicts premiums would decrease by about 8 percent to 11 percent compared with their costs under current law. This is consistent with estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent. In addition, about two-thirds of New Mexicans could potentially avoid subsidies or Medicaid, and nearly a quarter would qualify for near full subsidies or Medicaid.

An overall decrease in premium costs also is consistent with the experience in Massachusetts where there has been an enormous reduction in the cost of non-group insurance in the State after they enacted similar reform to what we are considering now in the Senate. After reform the average individual premium in Massachusetts fell from $8537 at the end of 2006 to $5143 in mid-2009, a 40 percent reduction while the rest of the Nation was seeing a 14 percent increase.

Finally, much of the debate on health care reform has focused on insurance coverage but it is important to recognize that as we expand coverage to include more Americans, the demand for health care services will also increase. A strong health care workforce is therefore essential for successful health reform. Within the United States, 56 percent of counties are designated health professions shortage areas—a measure indicating that there is insufficient medical staff to properly serve that geographic area. The problem is even more apparent in rural States such as New Mexico. For example, 32 out of 33 counties in my State has this shortage designation. As a result, New Mexico ranks last compared to all other States with regard to access to health care and utilization of preventative medicine.

The Patient Protection and Affordable Care Act we are debating contains key provisions to improve access and deliver high-quality health care services throughout the Nation. These provisions include increasing the supply of physicians, nurses, and other health care providers; enhancing workforce education and training; and providing support to the existing workforce. I applaud Senators REID, BAUCUS, DODD, HARKIN, and many other colleagues who have worked so hard on this bill. This legislation represents true healthcare reform. It is time for the major parties to put partisanship aside and enact this critical and long overdue legislation.

I see my time is up and there are others waiting to speak. I yield the floor.

EXHIBIT 1
[From the New York Times, Dec. 4, 2009]

By Paul Krugman

Health care reform hangs in the balance. Its fate rests with a handful of “centrist” senators—senators who claim to be mainly worried about whether the proposed legislation is fiscally responsible. But if they’re really concerned with fiscal responsibility, they shouldn’t be worried about what would happen if health reform passes. They should, instead, be worried about what would happen if it doesn’t pass. For America can’t get control of its budget without controlling health care costs—and this is our last, best chance to deal with these costs in a rational way.

Some background: Long-term fiscal projections for the U.S. are grim in the picture. Unless there are major policy changes, expenditure will consistently grow faster than revenue, eventually leading to a debt crisis.

What’s behind these projections? An aging population, which will raise the cost of Social Security, is part of the story. But the main driver of future deficits is the ever-rising cost of Medicare and Medicaid. If health care costs rise in the future as they have in the past, fiscal catastrophe awaits.

You might think from picture, that extending coverage to those who otherwise would be uninsured would exacerbate the problem. But you’d be wrong, for two reasons.

First, the uninsured in America are, on average, relatively young and healthy; covering them wouldn’t raise overall health care costs very much.

Second, the proposed health care reform links the expansion of coverage to serious cost-control measures for Medicare. Think of it as a grand bargain: coverage for (almost) everyone, tied to an effort to ensure that health care dollars are well spent.

Are we talking about Medicaid, or just window dressing? Well, the health care economists I respect are seriously impressed by the cost-control measures in the Senate bill, which include tight controls on Medicare, limiting the government’s share of Medicare spending, and imposing incentives for cost-effective care, the use of medical research to guide doctors toward treat-
They need. It gives them the chance to obtain the services and supports this morning. This program was at the heart of the Senate from Massachusetts. Mr. KIRK. Mr. President, I thank Senator BAUCUS.

AMENDMENT NO. 2706

Mr. President, today in the United States of America, approximately 200 million of our citizens are elderly or disabled. These are not mere statistics. They are family members and loved ones—vulnerable, challenged, and often forgotten. But they were not forgotten by their friend and advocate, Senator Ted Kennedy. He understood a fair and civilized society should be judged on how it treats its most vulnerable citizens.

Sadly, millions of seniors and persons living with disabilities struggle to obtain the services and supports they need to live long lives and remain active in their communities among their friends and families—in what they hoped would be their productive golden years.

As Senator Kennedy understood, it is morally wrong for so many disabled men and women who need assistance to be forced to face the heartbreaking choices: Do I abandon my job, spend down my savings, move out of my home, give up my American dream in order to qualify for Medicaid, the only government program that can provide me with the supports I need, or do I forgo my independence and resign myself to living the rest of my life confined to a facility?

Senator Kennedy also understood it is morally wrong when that infirm or elderly individual’s friends or loved ones must also face heartbreaking choices: Do I abandon my job, spend down my savings, move out of my home, give up my American dream in order to qualify for Medicaid, the only government program that can provide me with the supports I need, or do I forgo my independence and resign myself to confining my aging mother or father to a facility?

Families across this country understand this heart-wrenching crisis all too well. A recent SCAN poll found that nearly 60 percent of those surveyed had a personal experience with long-term care. As this chart demonstrates, nearly 80 percent would be more likely to support health care reform if it included a long-term care program. These families know the current long-term care industry is not meeting their current needs and that change must come.

As always, Senator Kennedy cared how our society would be judged. He did not just sit by. He acted. He drafted the Community Living Assistance Services and Supports Act, known as the CLASS Act, which we are debating this morning. This program was at the heart of his effort to help people with functional limitations and their families to obtain the services and supports they need. It gives them the chance to maintain their independence and remain active, productive members of their communities.

Under the CLASS Act, a worker in Massachusetts, or any other State, can choose to pay a premium into this voluntary insurance program through affordable payroll deduction. If contributing for 5 years, they become eligible for a cash benefit of at least $50 a day if they become disabled. That cash benefit can make the difference in allowing a disabled person to live with independence, self-respect, and dignity. For example, for having a ramp installed to their home or to pay for needed transportation or to purchase a computer to work from home and remain self-sufficient. It can also pay for a caregiver to come to their home, help them bathe, get dressed, and cook meals—services that otherwise often fall to family and friends who are forced to work reduced hours on their own jobs or quit those jobs altogether to provide that needed care.

Currently, as we know it, is paid for through a fragmented combination of sources, including family budgets, Medicaid, Medicare, and private insurance. Without a prior and voluntary insurance investment, many people will turn to Medicaid, the already overburdened Medicaid system. Today, Medicaid spends nearly $50 billion a year on long-term services and supports. Estimates indicate that by 2045 that spending could exceed $200 billion. Obviously, this current course is unsustainable.

In addition, the private insurance industry is not doing enough to meet the growing demand for long-term care. Rising baby boomers and longer lifespans will increase the demand for long-term care dramatically for decades to come. Yet 95 percent of people over age 45 do not have private long-term care insurance, and fewer and fewer people are able to buy such coverage.

Make no mistake, as it stands today, if someone without adequate long-term care coverage becomes disabled, they will more than likely have to turn to the already overburdened Medicaid system to get the help they need. The CLASS Act is designed to specifically remedy this looming crisis by giving people an affordable option other than Medicaid. The act will save the system over $1.6 billion over the 75 years that people start receiving benefits.

Some opponents of the CLASS Act argue that the program will not be sustainable over time and that it will become insolvent and end up costing taxpayers large amounts. That argument could not be further from the truth.

Let’s give proper credit where it is due. With the help of our friends on the other side of the aisle, we have taken real steps to ensure that the program remains solvent for decades to come. The CLASS Act establishes a strong work requirement to make sure the funds continue to come into the program from the payroll tax deduction or from an individual’s voluntarily paid premium. It requires the Secretary of HHS to review and set the premium annually to ensure that the program will remain solvent for the next 75 years. It directs the Secretary, in addition, to review the cost projections 20 years into the future. Finally, it mandates that no taxpayer funds will be used to pay benefits.

Let me repeat that final point, since I have often heard it misrepresented.
No taxpayer funds will be used to pay benefits. Benefits will be paid through self-funded and voluntary premiums.

During the markup in the HELP Committee this summer, Senator Dodd led a main discussion about this program. With the help of the Republicans on the especially Senator Gregg of New Hampshire, additional safeguards were included to ensure that the act will stand on strong financial footing for years to come. After the committee adopted Senator Gregg's amendment to protect the solvency and the program won strong words of support from both parties. We credit Senator Gregg for that constructive contribution.

This CLASS Act will do all the things it should do. It will provide financial and health security to elderly and infirm Americans. It will strengthen Medicare. It will make health reform the exact thing the American people need.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 8 minutes to the Senator from Wisconsin, the chairman of the Special Committee to Preserve Social Security.

The ACTING PRESIDENT pro tempore. The Senator from Wisconsin.

Mr. KOHL. Mr. President, I thank you very much Senator BAUCUS.

I come to the floor to talk about the many ways in which this bill will have a positive impact for seniors.

Over the past year, we have seen confusion about what health care reform will mean for Americans and particularly for seniors. I had hoped that once the Senate voted to move forward with debate on one merged bill, we could offer some definitive answers on how health reform will help them. Unfortunately, here we are on the floor, continuing to send mixed messages about some of the key provisions. As chairman of the Aging Committee, I wish to help set the record straight for older Americans.

This health reform bill is not going to cut Medicare benefits. Independent groups such as the AARP and the National Committee to Preserve Social Security and Medicare have said this bill will strengthen Medicare and not harm it. AARP believes this bill will transition Medicare to a more efficient system, where quality health care outcomes are rewarded and waste, which experts believe accounts for up to 30 percent of Medicare spending, is reduced.

In terms of the cuts to Medicare Advantage, this bill will only cut back on overpayments to these private Medicare plans. Benefits will not be affected. AARP also supports these cuts because they understand that most of the overpayments are going to insurance company profits, not to seniors' benefits. This is, by necessity, complex. We cannot gloss over these vital issues. So I would like to take a minute to share with you some of the provisions that have not received much attention but are, nevertheless, crucial to improving America's health care. There is a lot in this bill for older Americans, retirees, and those planning ahead for a healthy and happy long life. The Aging Committee has worked closely with the leadership of the HELP and Finance Committees to improve several of the provisions, most of which have bipartisan support. I wish to particularly thank Senator BAUCUS, Senator DODD, Senator HARKIN, and Majority Leader REID for being so willing to work with us on these issues.

We have enlisted help from seniors groups of every stripe to ensure health reform makes commonsense improvements that, in some cases, are desperately needed.

This bill will significantly improve the standard of care in nursing homes nationwide for the first time in 22 years. I thank my colleague, Senator GRASSLEY, for working together to make sure this important issue was not overlooked as part of health reform. In and of itself, this is a huge undertaking, but it is just one piece of the puzzle to comprehensively reform our health care system.

This bill will also train and expand the health care workforce so they are prepared to care for the growing elderly population. By implementing recommendations from the Institutes of Medicine, we will begin to address the severe shortage we face of direct care workers.

This bill will protect vulnerable patients by creating a nationwide system of background checks for long-term care workers. This policy is more than just a good idea in theory. We have implemented it in seven States and seen its results. Comprehensive background checks are routine for those who work with young children, and we should be protecting vulnerable seniors and disabled Americans in the same way.

This bill will make it easier for seniors to get the care they need in their own homes because when it comes to long-term care, one size does not fit all. The goal of long-term care should be to allow older or disabled Americans to live as independently as possible.

This bill will help us address our current long-term care system in order to offer choices tailored to an individual's needs. It will also help to alleviate the huge financial and emotional burden on married couples who need long-term care and their families. Committee colleagues, I yield the floor to my colleague, Senator CANTWELL, to ensure that married couples who receive care in their home and community are not required to spend the vast majority of their assets to receive assistance.

The committee has also helped to include a provision that will benefit all Americans regardless of age by helping to lower the costs of prescription drugs and medical devices.

Our policy aims to make transparent the influence of industry gifts and payments to doctors.

Although these are only a few of the Aging Committee's priorities, this bill makes many other improvements to our current health care system for older Americans.

The Senate bill will reduce the cost of preventive services and add a new focus on paying doctors to keep patients well and not just paying them for when their patients get sick.

Today, seniors pay 20 percent of the cost of many preventive services. By eliminating the copayment and deductibles through Medicare for important services such as immunizations, cholesterol screenings, bone calcium-level screenings, and colorectal screenings, we will help save lives as well as lower health care costs.

The bill will also provide for the first time an annual wellness visit at no cost to the beneficiary. Patients will be able to receive a personalized health risk assessment for chronic disease, have a complete review of their personal and family medical history, and receive a plan for their care.

This bill will remove the ability of insurance companies to deny access to consumers based on preexisting conditions. We know having health care is essential throughout one's life from beginning to end, but many older Americans count the days until they become eligible for Medicare because they are not able to find insurance coverage at any cost due to a health condition in their past.

I could go on about the many other improvements, small and large, that will benefit our Nation's seniors, but I will stop here and simply urge my colleagues to work to educate seniors and not scare them about the important changes this bill will make to provide them with better health care at lower cost.

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

Mr. BAUCUS. Mr. President, how much time remains for the majority?

The ACTING PRESIDENT pro tempore. Five minutes.

Mr. BAUCUS. I ask unanimous consent that there be an additional 5 minutes on each side.

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

Mr. BAUCUS. Mr. President, I yield the remaining time to the Senator from Oregon, which should be 10 minutes.

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

Mr. WYDEN. Mr. President, I wish to spend a few minutes this morning talking about Medicare Advantage and particularly to highlight the fact that I
I think it is important to support the language put together by the chairman of the Finance Committee on Medicare Advantage and to reject the amendment offered by our friend from Utah, Senator HATCH.

I wish to begin my comments with respect to Medicare Advantage by pointing out that it is clear that not all Medicare Advantage is created equal. Some of Medicare Advantage is a model of efficiency, and some of it is pretty much a rip-off of both taxpayers and seniors. I would refer, as it relates to the abusive plans, to the very important hearings chaired by Senator BAUCUS in the Finance Committee. I recall on one occasion sitting next to our friend from Arkansas, Senator LINCOLN. We had witnesses describe how Medicare Advantage was being sold door-to-door in her part of the country by individuals dressed up in scrubs as physicians and health care providers. In the discussion of how to handle it, we looked at various kinds of reforms to rein in abusive practices. I came to the conclusion that when you do something such as that, the CEOs ought to be put in jail. That is what is documented on the record as it relates to the Finance Committee and the Senate Finance Committee and why I come to the floor to make it clear that I think it is important to distinguish between the good-quality Medicare Advantage plans and those that have been living high on the hog through some of the overpayments we have documented on this floor.

My State has the highest percentage of older people in Medicare Advantage in the country. I had an opportunity to work closely with Chairman BAUCUS in terms of addressing Medicare Advantage, and I think that with the chairman’s leadership, it has been possible to show you can find savings in the Medicare Program without harming older people, without reducing their guaranteed benefits, their essential benefits, as we have learned, with Medicare Advantage. The way Chairman BAUCUS goes about doing that is by forcing the inefficient Medicare Advantage plans to follow the model of the efficient ones. The way we have been able to do that is essentially through a two-part strategy: first, encourage competitive bidding and, second, provide incentives for quality, which is done through the bonus payment provisions that are in the legislation.

First, on competitive bidding, you have plan bids, and you use the plan bids to set Medicare Advantage benchmarks which would encourage the plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to those who are enrolling. With the competitive bidding, plans compete to be the most efficient and hold down costs. I commend Senator BAUCUS for making this a central part of the way Medicare Advantage would be handled. Certainly our part of the country has shown this as a path to get more value for the Medicare Advantage dollar in the days ahead.

In addition, in the Finance Committee I offered an amendment with several colleagues that would boost the payments to those plans that, according to the government and the government uses a system of stars, in effect, to reward quality—our amendment would boost the payments to those Medicare Advantage plans with four- and five-star quality ratings. So, in effect, legislation there are both carrots and sticks. Competitive bidding plus bonus payments offers both, so the plans compete to provide the best value for seniors. By encouraging the plans to be more efficient, it is possible to achieve significant savings for older people, help shore up the solvency of the Medicare trust fund, and meet the cost-saving goals of the legislation.

One point that has been discussed by colleagues on the floor of the Senate is this matter of individuals being able to keep what they have. I have heard that is not the case with Medicare Advantage plans; that somehow, under the legislation that has been offered by the Finance Committee and the Senate Finance Committee and say to them, No. 1, take out the cuts in Medicare, and No. 2, any savings in Medicare must go to make Medicare more solvent. That is what that amendment accomplished. That was defeated. Fifty-eight Democrats said yes to the cuts in Medicare. They said yes to using the money that comes from these cuts to create a new entitlement program. Fifty Republicans and two Democrats said, no, we don’t want cuts to Medicare and we do not want a new entitlement program.

So yesterday we made it clear that the central core of Medicare includes nearly $5 trillion in cuts to Medicare. There is no question about that. Everyone concedes that. The President said that when he addressed us. The Congressional Budget Office says that. The American Medical Association said that. The Republican Senators said that. The cuts in Medicare are a bad idea, and yesterday, by 58 votes, the Democrats said yes to these cuts in Medicare.

Today, we want to talk about one aspect of those cuts which is Medicare Advantage. We are going to talk about these cuts in a careful, accurate way so the 11 million seniors who have Medicare Advantage understand exactly what the risk is to their Medicare Advantage policies.

We know that a portion of the overall Medicare cuts that the Democrats approved yesterday is a $120 billion cut over the next 10 years to the Medicare Advantage program. Now, what is Medicare Advantage? Medicare Advantage is an option seniors have. If you choose this option, Medicare pays a fixed amount every year for your care, to companies that might come to you and offer a Medicare Advantage plan which you can choose instead of the original Medicare plan.

Many seniors choose these plans—that is about 11 million seniors. Nearly one out of four seniors in America who are part of Medicare chooses the Medicare Advantage plan. In my home State of Tennessee, the number is about 230,000 Tennesseans.

Why do they choose it? Well, it is clear that when he addressed us. The Congressional Budget Office says that. There is no question about that. Every- one concedes that. The President said that when he addressed us. The Congressional Budget Office says that. The American Medical Association said that. The Republican Senators said that. The cuts in Medicare are a bad idea, and yesterday, by 58 votes, the Democrats said yes to these cuts in Medicare.
The distinguished Senator from Oregon was on the floor and he mentioned grandma. I have mentioned grandma a few times—no disrespect to grandma; he is in a boat. So, I didn’t need to worry about her Medicare care advantage plan because none of the benefits would be cut. That is not what the Director of the CBO, who is often cited by the chairman of the Finance Committee, has said. He said that half of the benefits currently provided to seniors under Medicare Advantage would disappear under the Finance Committee plan, which is much like the plan we are considering. The benefits that would disappear would include those I mentioned.

Today, with Senator McCain leading the discussion, we wish to talk about the Medicare Advantage plan, and why cuts to Medicare Advantage play a central part of this $2.5 trillion bill. Cuts to Medicare Advantage, which is about half of the $2.5 trillion cost, and the ones we are talking about today are the Medicare Advantage plans. I understand there will be an amendment by Senator Hatch, who has joined us, and I am sure he will talk about his own amendment. He was present on the Finance Committee when Medicare Advantage was created. I understand there will be an amendment to send this back to the Finance Committee saying don’t cut Medicare Advantage.

Mr. MCCAIN. Yes. For those who missed Senator Hatch’s important statement last night, which he will add to today, I point out that he was able to take a trip down memory lane. In June 2003, when the Medicare Modernization Act was before the Senate, several of our colleagues, including Senators Schumer and Kerry, offered a bipartisan amendment on the floor to provide additional funding for benefits under the Medicare Advantage Program.

But amnesia is not confined to one side of the aisle around here. I ask my friend from Tennessee—you know this discussion about Medicare Advantage—we have to better understand what is this program and why is it so popular. Is it because it offers seniors a chance to get additional benefits? Maybe the Senator can give a short definition of that. I think the American people may not be totally clear on what we are discussing. It is $2.5 trillion cost, and let’s make it clear: AARP will receive $18 million in stimulus money. There is a job creator for you. AARP, which has given its full-throated support to the Democratic health care legislation, even though seniors remain largely opposed, received an $18 million grant in the economic stimulus package for a job training program that has not created any jobs, according to the Obama administration’s recovery.gov Website. That is a case in point. Because from everything I have ever seen, they have created millions of jobs, including in the ninth congressional district of Arizona, where they said they created thousands of jobs. Unfortunately, we only have eight congressional districts, but that is OK.

In February, Politico reported that AARP was putting pressure on Republican Members of Congress to support the stimulus package. Senator McCaskill of Missouri has moved only for passage of health care legislation, even though Democratic proposals have called for several hundred billion dollars in cuts to Medicare—a program that the group typically defends tooth and nail when Republicans propose cutting it. It turns out that AARP is also in a position to benefit financially if the health care legislation passes, because seniors losing benefits as a result of cuts to Medicare Advantage will be forced to buy Medigap policies, which is the main source of AARP revenue. Barry Rand, chief executive of AARP, was a big donor to the Obama campaign and has retained a cozy relationship with the administration. That is shocking news.

So, my friends, also I might add that in 2006, AARP received $18 million from the Federal Government, and we are reserving additional Federal moneys that they get. The most important thing is this, and let’s make it clear: AARP will receive direct benefits because seniors deprive them of what we have every single day we are members of the Senate.

That is an exercise in hypocrisy. The Senator from Pennsylvania has it right, because the President, time after time, said to the American people: If you like the insurance policy you have today, you can keep it. How many hundreds of times have we heard him say that at townhall meetings? And his administration mouthed the same thing. The Senator from Pennsylvania is right when he says, “We are not going to be able to say if you like what you have, you can keep it. That basic commitment that a lot of us around here have made will be called into question.”

I will say a couple words, and I will talk more about this later. Every time the Senator from Montana and others are on the floor, they talk about the fact that AARP is the only institution that has a blantant transfer of funding from the Medicare Program, which the senators have earned, into a brand new entitlement—a $2.5 trillion entitlement program. That is what this bill is all about.

So, for your information, for your information, for your information, Mr. ALEXANDER. Yes, lower income Americans also choose these. They often choose it because it is the plans generally offer these benefits: dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated chronic care management, and physical fitness programs.

Mr. MCCAIN. Thank you. I wish I could mention that Medicare Advantage would allow seniors to have dental care, vision care, hearing care, physical fitness—it is fascinating. This allows our senior citizens to have dental care, vision care, hearing care, and physical fitness. It is fascinating. So, we will get the cost of that, although that may be hard to do.

Let me get this straight. Again, the American people should understand this. We criticize a program that seniors have taken advantage of, which gives them additional hearing, vision, dental, and physical fitness care, while we practice it here every single day. Every day, there is a physician on duty more than one—not very far from where I speak, who is ready to give us instant care. If hospitalization is needed, we can get instant transportation to the Bethesda Naval Hospital, where we will get free care. Incredibly, the Senate, on largely partisan grounds, voted against the Medicare Advantage plan, and why is it so popular with 330,000 senior citizens in my own State and 11 million in the country.

Mr. ALEXANDER. I can do that. The Senator is correct. If the Senator from Pennsylvania, Senator Casey, said that, he is merely repeating what the Director of the CBO stated, when he said that fully half of the benefits of Medicare Advantage will be lost.

To answer the Senator’s question, Medicare Advantage is an option that 11 million of the 40 million seniors who are on Medicare have chosen. The reason they choose it is because it is a plan offered by private companies, often to people in rural areas, often to minorities.

Mr. MCCAIN. I thank my friend. The reason I asked him to mention that Medicare Advantage would allow seniors to have dental care, vision care, hearing care, physical fitness—it is fascinating. This allows our senior citizens to have dental care, vision care, hearing care, and physical fitness. That is a little strange because, as was pointed out to me, that is exactly what we have here in the Senate. About 100 pages from here, if I need some doctor care immediately, if I need some vision care, if I need some dental care, I can get it. Next to my office in the Russell Senate Office Building, for the last several months—and I don’t know at what cost, but I would like to get entered into the RECORD how many tens of millions of dollars it is. But they are removing a guarantee yesterday voted against keeping the Medicare Advantage Program, when we have, right here, the best Medicare Advantage Program ever heard of in the world—free hearing, free vision, free dental—and they are expanding a gymnasium in a many-months-long project. I will get the cost of that, although that may be hard to do.

The title of that is “Dom Senator Says Medicare Advantage Cuts Break President’s Pledge.”

Maybe the Senator from Tennessee can give me a brief outline of what seniors get under Medicare Advantage and why it is so popular with 330,000 senior citizens in my State and 11 million in the country.
who have cuts in their Medicare Advantage and other Medicare programs can buy—guess what—a Medigap insurance policy from AARP—in other words, to cover the things being cut back under this legislation, and it costs $175 a month. The Medicare Advantage plans are zero for most seniors or $35 a month. Again, if the Medicare Advantage plans go away, people would have to buy a Medigap plan sold by—you got it—AARP. And some low-income seniors could not afford that.

That is why the Senator from Tennessee stated that if we drive people out of Medicare Advantage, we are harming low-income seniors all over this country. We are harming them. We are doing them a great disservice. If you think with 17 percent real unemployment in my State that seniors who are unemployed and down on their luck are going to be able to afford the AARP Medigap policy for $175 a month, come and visit my State and I will tell you they can’t.

It is interesting, the conversation about high-income seniors, and how we are going to tax people with Cadillac plans and all of those things, when what we are doing is harming the lowest income seniors in rural areas of America.

Mr. KYL. Will my colleague yield for a quick point?

Mr. MCCAIN. No.

Mr. KYL. The Senator was making the point that you cannot take $120 billion out of the program without hurting folks. Those on the other side of the aisle said we can do that—we can cut it by $120 billion and it still won’t hurt anybody. My colleague asked the Senator from Tennessee exactly what some of the benefits were and he repeated them. I went to get the actual statistical number of how much it will actually reduce benefits in terms of actuarial value. According to the Congressional Budget Office, in the year 2019, when fully implemented, here is the statistic: The actuarial value of the reduction in benefits under Medicare Advantage is 61 percent; in dollar terms, it goes from $135 a month down to $49 a month. In other words, the very things my colleague talks about—vision care, dental, all of those things—

Mr. MCCAIN. All of the things we routinely use in the Senate. I hope those who voted to harm the seniors in this country and not allow them to have dental, vision, and other health care would unilaterally disavow the decisions they made hundreds of millions of dollars more because they provide the Medigap policies people will be deprived of when we kill off Medicare Advantage? AARP.

Mr. ALEXANDER. Mr. President, I see the Senator from Texas, the Senator from Idaho, and the Senator from Wyoming have all come to the floor, in addition to the sponsor of the motion, Senator HATCH. I am sure they are prepared to reflect on who is hurt by these cuts.

The only thing I would emphasize is what the Senator from Arizona has said is that disproportionately low-income Americans in Texas, Idaho, Tennessee, Wyoming, and Utah are hurt. Only one-third of eligible White seniors and only 24 percent of eligible African American beneficiaries are enrolled in Medicare Advantage. But the number increases to 43 percent of its $1.17 billion in revenue in 2007 from 11 percent of its $120 billion cut something that doesn’t make sense. We are going to try to fix that situation.

The reason I bring up this issue, present-day Medicare beneficiaries do not have vision, they do not have dental, they do not have fitness. Yet, we in the Senate enjoy it every single day. So yesterday we voted to deprive seniors from the ability to have the same privileges that we enjoy every single day in the Senate. I would argue that is an exercise in hypocrisy.

Mr. ALEXANDER. I might say we are operating under a colloquy managed by Senator MCCAIN. So Republican Senators are free to engage in discussion. Mrs. HUTCHISON. Mr. President, I very much appreciate what the Senator from Arizona has said that disproportionately low-income Americans are going to lose vision care, dental care, the hearing aids. It is an affordable extra option.

In Texas, we have over 500,000 seniors enrolled in Medicare Advantage. One of the great things about Medicare Advantage, it is that it is available in rural areas, and it gives them choices that they might not be able to afford with other programs that are Medigap. This one is affordable. That is why we are fighting so hard to restore the cuts to Medicare Advantage.

Medicare Advantage costs about 14 percent more than traditional Medicare because it provides a wide range of these extra benefits we have discussed—dental, eye care, hearing aids in many cases, it pays providers more. Republicans, of course, are open to discussing how to improve the Medicare Advantage payment formula. We want to be more efficient with taxpayer dollars, but do we want to do that in the context of creating a massive new entitlement program and ask Medicare to pay for it or to cut life-saving benefits for seniors? Is that what we want to do, I ask Senator CRAPO?

Mr. CRAPO. That is absolutely the case. I would like to point out, when we had the Finance Committee markup, I asked CBO Director Elmendorf directly whether provisions in the bill,
which are still in the bill, would reduce the benefits that Medicare recipients received. His response was:

For those who would be enrolled otherwise under current law, yes.

There has been a lot of talk here about we are not cutting Medicare benefits, and the bottom line is, the CBO Director said it: Yes, we are cutting benefits.

I would like to ask the sponsor of this motion a question because I know there are some who are saying the reason we are cutting Medicare Advantage is that it is too expensive, and we should be cutting Medicare and controlling its costs; that it is about 14 percent more expensive than fee-for-service Medi-

Some people say if you are defending Medicare Advantage, you are defending overpayments in health care plans. Would the Senator from Utah like to respond to that criticism some are making?

Mr. HATCH. I would be delighted to.

To be clear, so-called overpayments to Medicare Advantage plans do not go to the plans. As a matter of fact, they go to the seniors in the form of extra ben-

The Senator from Arizona has mentioned in these articles, the Associated Press and USA Today said:

Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medi-


I look at this and say this is not fair to our seniors, not fair to the patients. I have taken care of for 25 years in Wy-


Mr. President, 11 million Americans have chosen Medicare Advantage because it is a wise choice to make be-

Mr. BARRASSO. It is also no surprise when people read about this and learn about it that they would want to be on Medicare Advantage. What the Senator from Utah has said, the sponsor of this motion, is that the money that goes into this program is for the benefit of the seniors. It is for services for the seniors on Medicare. To me, this whole bill basically guts Medicare, raids Medicare to start a whole new pro-

Mr. MCCAIN. I don't think they have as nice a gym, though, as we are going to get.

Mr. BARRASSO. Just as we do. It works in preventive care and coordi-

Mr. BARRASSO. It also is no surprise that claim that the government cannot make sure Medicare is around for future genera-

Mr. MCCAIN. We are listening to only one of the two doctors in the Senate who knows, has been on the ground, has met with the people, who understands what this means to senior citizens. One-third of them are on Medicare Advantage.

In the end, I believe we not only ac-

The reality is, as the Senator from Utah already indicated, 75 percent of this 14 percent extra payment in these plans go to provide the seniors with the extra benefits we are talking about, and then 25 percent is returned to the Federal Government.

I have a chart. We are going to make it into a bigger one. But those who sup-

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Mr. MCCAIN. I don't think they have as nice a gym, though, as we are going to get.
a moment—I believe you were in the Finance Committee markup where the bill was being written that was offered by the distinguished Finance Committee chairman, and I believe you were talking to the head of the Congressional Budget Office, who is often cited by our friends on the other side as the nonpartisan authority for exactly what the bill does, and you asked him whether the benefits of Medicare Advantage recipients would be cut. Would you describe that in a little more detail so people understand exactly the scenario?

Mr. CRAPO. Yes, I would. This chart shows the last two sentences of our colloquy when we were in the Finance Committee, but it went on for some time. But the bottom line is that I was asking the Director of CBO whether the cuts to Medicare Advantage that are in the bill would reduce benefits to senior citizens, and he said yes. And the reason he used this phrase here, which someone would be entitled otherwise under current law,” the reason he prefaced it that way—which we don’t have on the chart—is that for future seniors it will not be a viable option. So in the future, those who are not on it now won’t have a significant viable option to get on it because it is going to be gutted.

So he was saying that for those 75 percent—and by the way, Medicare Advantage is the most popular part of Medicare today. It is the fastest growing program. It is popular because it provides these additional benefits that seniors have to pay so significantly for to get in supplemental insurance that AARP is going to provide. So what the CBO Director said was that for the future, those who aren’t already on it won’t get it.

Mr. McCAIN. Could the Senator from Texas and I go back to one of the things I mentioned earlier, because in Texas, how many are under Medicare Advantage?

Mrs. HUTCHISON. Five hundred thousand of my constituents are on Medicare Advantage.

Mr. MCCAIN. Five hundred thousand in your State, and there is no “shielding.” According to this Bloomberg article and according to our knowledge, it says:

Senator Charles Schumer of New York, Bill Nelson of Florida, and Ron Wyden of Oregon are among those who secured special provisions shielding constituents from cuts. Casey—

Referring to Senator CASEY of Pennsylvania—

says he wants “very comparable” protections for his State—surprisingly enough—where more than one-third of Medicare beneficiaries participate in Medicare Advantage. “It’s the kind of thing that will likely be addressed on the floor,” he said.

Well, I eagerly look forward to working, on the other side of the aisle, with all 17 percent of those States, with the exception of New York, Florida, and Oregon, who have earned special shielding from these cuts. I look forward to working with them, and let’s fix it for all of us; right, Senator HATCH?

Mr. HATCH. That’s right. Go ahead. Mrs. HUTCHISON. Yes, I would say to the Senator from Arizona, I was wondering if every State could have the same treatment. Why not have every State get this shielding for their Medicare Advantage? That is 11 million people in this country who would then be helped by a fair assessment of all over the country.

But let me just point out one other provision. The way they have been shielded is through grandfathering. What about people who—

Mr. McCAIN. And was that shielding done on the floor of the Senate, in open debate and in discussion of the issue?

Mrs. HUTCHISON. Oh, no. Now, amazingly—

Mr. McCAIN. It was done in an office over here, where we still await the white smoke.

Mrs. HUTCHISON. The white smoke, that is correct. But then the question arises: What about the future, where people will say: That is what I can afford and what I want to have. But grandfathering doesn’t include anyone that may want to join in the future; it is only the people already in the system. And for how long they live, that is great, but what about the future?

So this is a great program. It is affordable for the lower income people. This shielding is only for three States now, but I would like to see all of us have the same capabilities for our constituents. And what about our future constituents?

Mr. GREGG. Would the Senator yield on that point, because the Senator from Arizona has raised an important point. If this is such a good program for these four States, why isn’t it a good program for everybody?

But more importantly, the Senator is the expert around here on earmarks. Is this not a classic earmark? And didn’t we hear from the other side of the aisle that we were going to have open government; that we were not going to have this type of exercise occur within major bills: that bills weren’t going to be loaded up with special earmarks assisting one Member or another? As the expert on the issue of earmarks, would the Senator comment?

Mr. McCAIN. I would say this is probably the classic hometown protectionism that we see in earmarking and benefits that we see in the earmarkng process.

But also, I would remind the Senator from New Hampshire, as we have all discussed several times, a year ago last October, our then-candidate for President said: It is all going to be on C-SPAN. Well, the C-SPAN cameras are still waiting outside Senator Reid’s offices to go in and film these negotiations so that, as President Obama said, all the action, all the negotiations, is on the side of the pharmaceutical companies and who is on the side of the American people.

Mr. HATCH. We are taking ¾ trillion out of a program that is going to be insolvent before the end of this decade and we are giving it to another program that is already insolvent.

Mr. GREGG. That will be insolvent. Mr. HATCH. That will be insolvent. It is almost insane what they are doing. And they wonder why the American people are having such a difficult time finding employment why we have an unemployment rate of 17 percent in this country. Those are people who are trying to get part-time jobs because they can’t get full-time jobs. So 17 percent is the real number. This whole program is about helping low-income people and minorities, when you stop and think about it. That is what Medicare Advantage does. As the distinguished Senator from Arizona has said, they can’t afford these supplemental policies on top of Medicare. For many low-income Americans and minorities, Medicare Advantage is the only way they can afford the supplemental coverage.

I compliment all of my colleagues who are on the floor—the distinguished Senator from Arizona; the distinguished Senator from Idaho; the distinguished Senator from Texas; our only
Mr. MCCAIN. Could I say again that we have had spirited debate and discussion on this floor, but it is clear the majority of the American people do not support the proposal that is before us, and that the Senate meeting in private, mostly in secret, closed negotiations.

I thank all of my colleagues for their many contributions. We are ready to talk. We are ready to talk, but we won’t be driven.

Mrs. HUTCHISON. Mr. President, I would like to return to a point that was made earlier about the President promising, and it being understood by everyone, that if you like what you have, you can keep it. On Medicare Advantage, once again, the CMS has estimated—and I would ask the distinguished Senator from Utah to verify this—that enrollment in Medicare Advantage will decrease by 64 percent under this bill.

Mr. HATCH. A lot of seniors are going to be badly hurt by these cuts, no question, and the poor.

Mrs. HUTCHISON. And 8.5 million seniors will lose all their savings.

Mr. HATCH. And a lot of them are minorities, by the way. This is amazing to me, how we go through all kinds of demagoguing about low-income people and minorities, and yet they are going to take one of the most important benefits away from them. That benefit is mentioned in the Medicare handbook for 2010, yet they act as if it is not part of Medicare. I can’t believe some of the arguments that have come from the other side.

Mr. MCCAIN. Could I ask the Senator from New Hampshire, the senior member on the Budget Committee, a person who is well-known for his knowledge of the economy, of the budgetary situation in America, what happens if we pass this massive bill? What happens to America’s economy?

Mr. GREGG. Well, my view is this: First off, we know a couple of facts—that we grow the government by $2.5 trillion over a 10-year period when this bill is fully implemented. We also know the tax increases during that period will be approximately $1.2 trillion, tax increases and fees, and they are not going to fall on the wealthy, they are going to fall on the small businessperson trying to create the extra job. We also know there will be an entire sea change in the way people get their health care, that the government will be stepped in. Senator GREGG and, of course, Senator ALEXANDER. You guys have really summed this up.

Mr. GREGG. I am suggesting it is very difficult, under any scenario, to believe this Congress is going to do anything other than spend the money that is put in this bill. It is certainly not going to end up making the reductions on Medicare it proposes in this bill. If it does not make billions, though, I think the Senator from Utah has been absolutely right in saying those reductions should go to making the Medicare system solvent. They should not go to creating a brand new entitlement.

Mr. MCCAIN. On that point I think Senator CRAPÓ wishes to exactly emphasize the point of Senator GREGG.

Mr. CRAPÓ. I wish to make a comment or two and then engage with the ranking member of the Budget Committee.

Often people talk about driving the cost curve down. Frankly, when you talk to Americans about what they want in health care reform, the vast majority of them say we need health care reform is because of the skyrocketing cost of health care and health care insurance. Those who are promoting this bill say they are bending that cost curve down. My question is which cost curve are they talking about? Is it the size of government? Are they bending the size of government growth down? No, as the Senator from New Hampshire said, they are growing government by $2.5 trillion for the true 10-year cost of the bill.

Are they driving personal health care costs down? No, as the CBO recently got said 30 percent of Americans will see their health insurance go up, and the other 70 percent will, at best, see it stay about what it is today, rising at the same levels it is today.

Are they talking about the Federal deficit? The chairman of the Budget Committee has indicated to us we are going to see skyrocketing deficits. Those who claim trying to reduce the deficit can say so only if they take into account all of their budget gimmicks, such as not counting the first 4 years of the spending, or the hundreds of billions of dollar of taxes that are going to be imposed on the American people, or the Medicare cuts we have been talking about. Take any one of those three out of this bill and it drives the deficit up in a skyrocketing fashion, is that not correct, Senator?

Mr. GREGG. Absolutely.

Mr. MCCAIN. Has the Senator from New Hampshire ever heard of legislation where you pay in the first 4 years before a single benefit comes about? Nowadays I see these advertisements that you can buy a car and you don’t have to make a payment for a year and then you can start making payments. In this deal it is the reverse; you make payments and then perhaps you get the benefits after some years.

Mr. HATCH. The Senator from Tennessee, I think, wishes to comment, too.

Mr. ALEXANDER. I would direct my comment to the Senator from New York.
Hampshire, too. The President of the United States said something a few weeks ago that I thought was profound and that I agreed with, he said this debate is not just about health care; it is about the role of the Federal Government in the everyday lives of the American people. You are going to exactly right about that, which is why so many Americans are turning against this bill.

Would the Senator from New Hampshire, the President was correct, that this debate is about, in my view, now, Washington takeovers, more taxes, more spending, and more debt? Is it not just about health care. The enormous interest across the country in these votes comes from a much larger picture than this health care bill.

Mr. GREGG. I think the Senator from Tennessee has once again hit the nail on the head. I respect the President’s forthrightness. The President has said very simply he believes that prosperity comes from growing the economy. When this bill passes, we will see the largest growth in government in the history of our country. This is going to be 16 percent of our economy basically managed by the Federal Government. You are going to see the Government explode in size. Does that lead to prosperity? I don’t happen to think it does. It certainly doesn’t lead to prosperity if along with that massive expansion in the size of the government, we are going to see your deficit go up significantly, your debt go up significantly, or the tax burden go up significantly, which reduces productivity, or if you take a large segment of our society, our seniors, 35 million today, 70 million by the year 2019, and say to them they are not going to have the ability to have a solvent Medicare system because the way that system might have been made more solvent is now being used to create a brand new entitlement, a massive new program everyone understands that. So you take almost a $1 trillion out of a program that is working for seniors, that gives options to seniors such as Medicare Advantage, and you take away their care to pay for another entitlement program that is not specifically designed for them. I thank the Senator from Arizona and ask him to finish the comments on what is happening to this bill, this country, and our seniors. We need to stop it.

Mr. McCAIN. I thank my colleagues. It has been a lot of fun. I yield the floor.

Mr. BAUCUS. Mr. President, if I may, I ask unanimous consent that we extend the time for the President’s four minutes remaining on the first block, on the majority side?

The ACTING PRESIDENT pro tempore. There is 2 minutes 20 seconds.

The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I ask unanimous consent to be added as a co-sponsor to Amendment No., the amendment that requires all Members of Congress to enroll in the new public health insurance option. I wish to add my name to Senator Coburn’s amendment. Seventeen years ago when I first ran for Congress I promised I would pay my own health insurance until Congress paid health insurance for everyone. I have paid out of my pocket since then. I look forward with great eagerness to joining the public option as soon as it is available.

Mr. BAUCUS. Mr. President, I think I will use my 2 minutes 20 seconds.

The ACTING PRESIDENT pro tempore. And 15 seconds.

Mr. BAUCUS. OK. I want to make three basic points. The Senator from Arizona talks about, gee, all these seniors, which is so important. I was reminded that we have not even talked about the $135 billion that would be taken out of hospitals in this bill. These are the care providers. We are talking about taking away benefit options in eye care and dental care and hearing aids, sort of basic things seniors need, but also undercutting the hospitals that treat them, so the care providers themselves would also have to be cut back.

It does not pass common sense to cut Medicare in order to create a new entitlement program. We have all said that Medicare is on life support anyway. So you take almost a $1 trillion out of a program that is working for seniors, that gives options to seniors such as Medicare Advantage, and you take away their care to pay for another entitlement program that is not specifically designed for them.

I thank the Senator from Arizona and ask him to finish the comments on what is happening to this bill, this country, and our seniors. We need to stop it.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might take. I don’t think I am going to speak more than 6 or 7 minutes, for the benefit of my colleagues who may want some of this time.

I want to tell my colleagues why I am supporting the Hatch amendment. In my home State of Iowa there are 64,000 seniors enrolled in Medicare Advantage. These are seniors who have come to rely on lower cost and particularly additional benefits that Medicare Advantage provides, as opposed to traditional Medicare. Yesterday I came to the floor to point out that my colleagues on the other side of the aisle are playing word games to cover up the fact that they are raiding Medicare, cutting benefits by 64 percent for these 11 million seniors who have chosen voluntarily to go on Medicare Advantage and opposed to traditional Medicare. Let me repeat: This bill cuts Medicare benefits, or let’s say raids Medicare, by 64 percent for 11 million Medicare beneficiaries.

My friends on the other side of the aisle keep saying they are not cutting and they use these words, “they are not cutting guaranteed benefits.” But this is not even the case. Because we have this new independent Medicare advisory board that is set up in this legislation, it is giving the authority to cut payments to Medicare Part D. This will result in higher costs and less guaranteed benefits for Medicare beneficiaries enrolled in Medicare Part D.

But I want to leave that debate for later. I want to visit with my colleagues now about Medicare Advantage. Mr. President, 64,000 seniors in Iowa and 11 million seniors nationwide do not care about the gobbledy-gook type words we use here in town, as long as the plans are “guaranteed benefits” on the one hand and the words “additional benefit” on the other hand. In other words, guaranteed benefits or,
as the other side wants us to believe, somehow additional benefits provided under Medicare.

I say that is Washington nonsense. I want to bring a little bit of Midwestern common sense to this debate. Our constituencies do not want to know that the so-called savings in Medicare is not cutting Medicare benefits they have come to rely upon and that would include, under Medicare Advantage, dental care, eyeglasses, hearing aids, and other additional benefits provided by this program that they voluntarily chose, Medicare Advantage.

I know that to be the case. I have at least 1,000 letters I have received since last summer on this point. But I want to refer you, if you will, to a letter from Purification S. Gallardo of Iowa City, IA.

I am writing to urge you to oppose cuts to Medicare Advantage. . . . This plan was a great help to me when my late husband, who passed away in May, was hospitalized. . . . I was able to afford to pay the hospital without going bankrupt. We seniors who live on a fixed income depend on our benefits from Medicare Advantage. I am retired and don’t know how I would have managed without [Medicare Advantage].

Some of my colleagues on the other side of the aisle don’t want seniors, even people such as my constituent from Iowa City, Ms. Gallardo, to know that this 2,074-page bill is cutting their benefits. Because the other side will say they are simply cutting so-called overpayments and making Medicare Advantage plans. That doesn’t make any difference to Ms. Gallardo. They fail to mention, 75 percent of these so-called overpayments must be spent for additional benefits—not only free money for a company to use or free money that benefits a Medicare Advantage recipient without any concern about what it costs—75 percent of these payments must be spent for additional benefits—not only free money for a company to use or free money that benefits a Medicare Advantage recipient without any concern about what it costs—75 percent of these payments must be spent for additional benefits. Then where does the rest of it go? The rest of it comes back to the Federal Treasury. Cuts to these Medicare Advantage payments are, in fact, cuts in Medicare benefits.

I am here today—happily—to have a debate on how to reform Medicare Advantage payments. We should always be looking for ways to make payments more efficient. But the solution is not to cut benefits by 64 percent, on which seniors have come to rely, to fund an entirely new entitlement program this country can’t afford. At a time when seniors are in the midst of the biggest economic crisis since the Great Depression, we should not be debating a bill that will force us to spend more money on health care, and that is exactly what this 2,074-page bill will do. Seniors who lose their Medicare Advantage as a result of this bill may be forced to buy a Medigap plan to fill in all the holes. Medicaid Coverage is why more low-income seniors enroll in Medicare Advantage. The so-called overpayments my colleagues on the other side of the aisle keep decrying help fill in the significant cost sharing and premiums that exist in traditional Medicare.

This bill will force low-income seniors, who pay little to nothing under Medicare Advantage, to come up with $175 per month to buy a Medigap plan. That doesn’t sound like that is a very good way to help seniors. That sounds like this bill is paying for an entirely new entitlement program and paying for it, quite frankly, on the backs of 11 million Medicare seniors.

I support the Hatch amendment. Let’s take the $120 billion in Medicare Advantage cuts back to the Finance Committee and find a way to improve the program without hurting 11 million seniors.

I yield 5 minutes, as the manager on this side, to Senator HUTCHISON.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mr. HUTCHISON. Mr. President, I appreciate what the distinguished Senator from Iowa has discussed. I specifically liked the fact that he is relating this to where we are today. Sometimes it seems as though we are in a vacuum, not realizing how stretched people are right now. We are in a time of joblessness, people are worried about keeping their jobs, worried about having lost their jobs, where they are going to get their health care. We have seniors who are some of the most vulnerable people not able to earn income. We are in a distressed time. There is no doubt about it. To talk about cutting Medicare by almost $500 billion is astounding. I am concerned about hospitals. We talked for the last 45 minutes about the cuts to benefits—the hearing aids, the dental work seniors need, the eye care seniors need.

What about the cuts to care provided in a hospital? Hospitals that treat a large share of low-income seniors get an extra payment from Medicare. Medicare already makes reduced payments to providers, to doctors but also to hospitals, to hospice, to nursing homes, and home health agencies for senior services. And, yet again, is proposed to cut almost $500 billion. All of these serve our seniors in such great ways. Look at the cuts, almost $5/4 trillion over 10 years. This is not sustainable. We cannot take away from Medicare, cut services, cut reimbursements to providers, to doctors but also to hospitals, to hospice, to nursing homes, and home health agencies for senior services. And, yet again, is proposed to cut almost $500 billion. All of these serve our seniors in such great ways. Look at the cuts, almost $5/4 trillion over 10 years. This is not sustainable. 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The Texas Hospital Association estimates that $2 billion will cut in payments to hospitals for treating a large volume of low-income Medicare patients, $2 billion out of our economy.

Mr. President, 254 counties in Texas, more than one-fourth, do not even have an acute care hospital within their boundaries. With these kinds of cuts to rural hospitals, we are talking about losing more hospitals. There is no doubt about it. They are already stretched to make ends meet, hard for seniors serving seniors and not getting paid the full cost of the treatment. Yet we are talking about cutting these services.

Of the $35 billion in Medicare cuts to hospitals, $2 billion is for the reimbursement rates that will no longer be making hospitals whole. I went to the major medical centers in Texas—in Dallas, Houston. Then I went to rural areas. It is the topic of conversation. Anyone who is dealing with a hospital in a rural area, they are all saying: What are you doing?

Of course, we are not doing anything. We are fighting these health care cuts. But we have to make sure they know what is happening so we can achieve this result.

I wish to talk about taxes, which is our subject, and in a different way than others did. The stated purpose of the Democrats’ health care proposal is to do two things: lower cost and increase coverage. This bill is a miserable failure on both counts. Under the plan, premiums are expected to increase, as a result of new taxes, new regulations, and restrictions. In general, you are going to pay more for better insurance thanks to the Democrats’ 2,000-page bill. This is in direct contradiction to the stated goals of the bill itself. I will be specific about that in a moment.

The second issue is coverage. Again, we find a miserable failure. The most often cited number of uninsured Americans is 47 million Americans. I saw some interesting numbers in a Washington Post opinion piece the other day which put the number of uninsured Americans, and how they are broken down. This is very significant. Of the 47 million, 39 percent reside in the five States of California, Florida, New Mexico, Arizona, and Texas. Those are our border States. Indeed, it is estimated that 9.1 million of the 47 million are illegal immigrants, people in this country illegally. Secondly, of the 47 million, 9.7 million have incomes above $75,000 and choose not to purchase health insurance. This bill would solve that issue by using the coercive power of the Federal Government to force citizens to allocate their resources in a manner that
meets the approval of bureaucrats in Washington and of politicians. The bill makes it a crime not to have health insurance. If you don’t get it, you get taxed.

Lastly, a total of 14 million of the 47 million Americans are currently eligible for current government programs—Medicaid, Medicare, SCHIP, and so forth—and choose not to sign up. If you do the math, that reduces that 47 million down, if you take out the illegals and the others for the reasons I stated, to about 14 million. So this, by and large, is what people are talking about when they mention the 47 million uninsured Americans. These numbers shed some interesting light on the composition of the number of uninsured Americans that gets thrown around. President Obama, interestingly, uses a different number. He doesn’t use 47 million. He uses 30 million. I think he wants to avoid the immigration issue, and it is probably wise of him to do so. He doesn’t want to be accused of giving rich benefits to people who are here illegally. I noted, with great interest, the CBO’s estimate of the number of Americans who will not have health insurance, even if this bill were to be enacted, as a product of the majority of the American people, 24 million. This bill still leaves 24 million Americans uninsured, after spending $2.5 trillion to do just that, while at the same time making health care more expensive and less available.

I hear the other side often throwing numbers around without any documentation. I use the CBO and other nonpartisan, credible sources so we can avoid doing that. President Obama wants to spend $2.5 trillion in new health care promises at a time when the country can’t afford the promises we have already made, and we have a record 1-year budget deficit which, by the way, means that 47 cents out of every dollar the Federal Government spends this year is borrowed. In 10 years, 16 percent or nearly $1 out of every $5 the government spends will be spent solely on interest payments on the debt. President Obama’s budget doubles the Federal debt in 5 years and triples it in 10 years. We have talked about this on the floor. I don’t think there is disagreement.

On top of this, we face $67 trillion in unfunded liabilities from our current entitlements—Social Security, Medicare, and Medicaid. This health care plan layers yet another unaffordable entitlement on top of Medicare and Medicaid and Social Security and the other entitlements we have, all in a system that is already crumbling. It seems to me this bill is exactly what the American people do not need. That is why most Americans are reporting that this bill is something they do not want at this time or ever. I think it is common sense.

Reading through the legislation, one is struck by the myriad of ways this bill raises taxes on America’s citizens—from job-creating small businesses, to middle-class families. I count about a dozen of them, adding up to about $500 billion in tax increases over the next few years—$½ trillion in new taxes. So everyone should get ready to pay a higher health care bill and a higher tax bill. And that means the cost of health care will go up in law.

Some might be inclined to say: But President Obama promised he would not raise taxes. That was, indeed, a campaign promise of the current administration, that no one making under $250,000 per year would see their taxes go up.

Let me just go ahead and quote that. This is what President Obama said during the campaign:

‘I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase—no your income taxes, no your payroll taxes, no your capital gains taxes, no any of your taxes.’

So we started analyzing this bill, and guess what we found out. When the bill is fully enacted, the nonpartisan Joint Committee on Taxation—keep in mind, I am quoting sources here that are credible sources and nonpartisan sources. The Joint Committee on Taxation found that, on average, individuals making over $50,000 and families making over $75,000 would see their taxes go up. Let me repeat that. Individuals making over $50,000 and families making over $75,000 would have their taxes go up under this bill. Indeed, according to the Joint Committee on Taxation, 42 million middle-class families and individuals—those making less than $200,000, on average, will pay higher taxes in this bill. President Obama’s health care reform bill currently under consideration in the Senate raises revenues to a large extent on the backs of middle-class Americans despite Candidate Obama’s pledge not to do that.

So let’s look at some of these instances where we get taxed. I am getting this, again, from the Joint Tax Committee and from CBO. If you have health care activities. According to the nonpartisan Congressional Budget Office, new excise taxes applied to health insurance providers will end up taxing the beneficiaries. This tax also has the effect of increasing premiums as well. So you are double-taxed on this deal.

Now, that is if you do have health insurance. What if you do not have health insurance? You still get taxed. Under this bill, you get taxed if you do not have health insurance, whether it costs anything. Where does this burden fall? You guessed it: middle-class Americans.

CBO has said that half of the Americans affected by this provision make between $22,800 and $68,000 for a family of four in this middle-class America. If you take prescription drugs, you get taxed. That is another area. According to the JTC and CBO, new taxes in the bill applied to the provision of prescription drugs will end up raising the cost of those drugs. So you are taxed again.

If you happen to need a medical device—this is something I am really sensitive to, and I have not heard much discussion of this issue on the floor so far. It is a difficult thing. I was talking to Senator Enzi. He said people do not really know what medical devices are. The stents—these are things that are available here in America. You cannot find them in many of the other countries. So if you need a medical device, you get taxed. If you have high out-of-pocket medical bills, you get taxed.

My son-in-law, Brad Swan, installs pacemakers, and I talked to him this morning. This morning, I was talking to him, and he told me what happened last night. He said that at 1 o’clock in the morning, they got a call to go out to the emergency room of St. Francis Hospital in my city of Tulsa, OK, and they had an 8-year-old boy who had no heartbeat. He was born with congenital heart disease. He put in a pacemaker at that time, and he was perfectly healthy in the morning. I think most doctors agree that if they give a child a pacemaker, they would not have lived. My older sister Marilyn faced a similar situation 9 years ago. She is alive today. She is healthy today. She would not be alive today without it. That is how serious this is.

Dr. Stanley DeFehr is from Bartlesville, OK. I talked to him this morning about this, about the significance of the medical devices. I am going to quote his answer. I wrote it down. He said:

‘The decision of who needs a pacemaker could be complicated, particularly the decision to put in a pacemaker on someone we might consider quite elderly. But it’s a false frame anyway. We could lose hundreds of millions of dollars—because of their risk of failing (breaking a hip or shoulder). In the case where they fail, the costs become quite high. The cost of a pacemaker pales in comparison to the cost of a stroke or multiple fractures.

A pacemaker, by the way, costs about $5,000 and lasts about 10 years. That is $500 a year—not a bad deal. So I think this is a quality-of-life issue that we would lose if we did not allow patients to have health care coverage. It is a quality of life that the beneficiaries would lose. It is a quality of life that the patients involved need. It is a quality of life that the taxpayers who would pay the tax on crisis—JTC and CBO are correct. They are correct.

So those are some examples of what we can do to pay higher taxes under this bill. If you have health insurance, you pay higher taxes. If you do not have it, you pay higher taxes. If you purchase a medical device, you have higher taxes. If you pay your own medical bills out of your pocket, you have higher taxes. If you take prescription drugs, you have higher taxes. All of these things could be taxed mercilessly under this legislation.

I want to turn now to examine one tax provision in particular that I find strikingly dishonest, damaging, and expensive to the taxpayer. It is an additional Medicare payroll tax that is in this legislation, and it is a perfect example of how this bill is going to tax you. You have to go into the bill to find these things. There are clandestine taxes in the bill that will hit you when you do not expect them to.

Basically, the bill says that people making $200,000 a year are going to pay an additional payroll tax called the
hospital insurance payroll tax that raises over $53 billion. Keep in mind, this is above the taxes we are already paying. They are getting these people at $200,000. You might think that is a lot of money. But there is a catch to this. They did not index it. So if you do not index the $200,000, then over the course of time goes by, and it is far less than the amount it sounds like today. In fact, I would say in 10 years from now that $200,000 would pretty much fit a lot of the middle-income people in America. So the reality is that with an additional Medicare payroll tax in this bill that raises $50 billion. It is not indexed, and we know how that is going to extend to other people now.

I remember Candidate Obama making a firm pledge not to raise taxes on middle-class Americans. However, this health care reform bill before us breaks that pledge on numerous occasions. But it is not unlike the new taxes which will be imposed on other measures. The bipartisan Congress President Obama would like to enact. I just mentioned the $500 billion in new taxes this health bill raises.

There is another tax in another program going on, which I have talked about before. Many times, that is the cap and trade. That is still on the floor. That could come up at any time. Of course, that is not something that would be $500 billion over a 10-year period; that would tax the American people in excess of $300 billion every year.

I have quoted sources, the Wharton School of Economics, MIT, CRA, and others that have done evaluations. So it is not just this bill, even though this bill is what we are talking about today; we still have the problem of other legislation being promoted by the President and by the Democrats here.

The Obama administration’s own Treasury Department estimated that cap-and-trade legislation would cost each family in America $1,761 a year. It is much more than that in heartland America. In Oklahoma, it would be closer to $3,300 a year. So we are talking about some very large tax increases.

But, again, back to the health care bill, I noted earlier that the government-run health care system, as proposed by the President and by the Democrats, is expected to cost $2.5 trillion on top of the already exploding record deficits. This bill will increase payments we make on our country’s ever-explooding Federal debt. This Democratic Congress’s agenda clearly includes more tax on Americans. They may be hidden, but they are there. It is disingenuous. It is costly. It is another reason this bill should not be passed by the Senate. I say “another.” The other and the main reason is that a government-run health system does not work.

The PRESIDING OFFICER. That is correct. The President has 30 minutes.

Mr. BAUCUS. Mr. President, I yield myself 10 minutes.

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

Mr. BAUCUS. Mr. President, I just want to help people understand this legislation. I am sure many do, but I am sure there are some who do not with respect to the choices people will have.

We have a uniquely American system of health care in America. It is roughly half public, half private. The goal of this legislation is to retain what we have; that is, basically have that same balance of public and private. It has worked pretty well for America. It is uniquely American. We are not Canada. We are not Great Britain. We are not Switzerland. We are the United States of America. I think it is good to build on our current system and make our current system work better.

I am prompted to explain the choices, in part by the statements by the senior Senator from Arizona, who said Medicare Advantage plans enable people to get eyeglass and dental care. And that is true. But he went on to say that, gee, shouldn’t Members of Congress, who like all that and want to keep all that—that Members of Congress get free dental and free eyeglasses. Well, that is really not true. Members of Congress do not get that. But it is true Members of Congress participate in—all Federal employees, Members of Congress, people in the Forest Service, people all around the country—all Federal employees participate in the same system. It is called FEHBP. It is the Federal Employees Health Benefits Plan, where Federal employees and Members of Congress, all together, the same, can choose among many different private health insurance plans. There is an open enrollment season—in fact, we are in the midst of it right now—where Members of Congress and all Federal employees can look to see if they want to choose a different insurance company or not. Some of those companies do provide dental and vision coverage. Some do not. So if a Federal employee wants to choose a plan that covers dental and vision, he or she can do so. Just pay the premium, and you are covered with dental insurance.

We are setting up under this legislation an exchange that is very similar—almost identical—to the FEHBP, where people who do not have health insurance can go look on the exchange and choose among private companies, which one makes the most sense for them. Some may have dental, some may have eyeglass coverage, some may not. That is just a choice people can make.

In addition to that, there is even more choice, because currently a Federal employee does not have to join FEHBP. A Federal employee can choose not to get health insurance if he or she does not want to or maybe they get it through their spouse someplace else. The same can be true with the exchange set up in this legislation. The person could buy among different competing private plans that offer health insurance, and the person can go outside the exchange because he or she thinks they can get a better deal, if that person wants to.

So I just want to make it clear that we are encouraging choice. We are encouraging competition. And I might say that under the legislation, Members of Congress who fully participate in this will be coequal with others. If there is a private option, Members of Congress can participate in that as well. In fact, we are requiring Senators and their staffs—they do not have to participate in the exchange, but it is certainly available to them, and they can opt out if they want to.

Let me just say a little bit about Medicare Advantage. Does MedPAC say about Medicare Advantage? Several years ago, Congress established an advisory board that is now called MedPAC to advise them on how Medicare should pay providers in traditional Medicare and private health insurers in Medicare Advantage. Again, Medicare Advantage is with private companies. They have executives. They have stockholders. They are private companies. MedPAC advises us how much Congress should pay MedPAC and other Medicare providers in traditional fee for service. It is an independent agency. Its experts are nonpartisan, highly respected.

Each year, they send a report to Congress that examines issues in Medicare. Here is what MedPAC had to say about the current state of Medicare Advantage in its 2009 June report. I am going to quote now from this independent advisory panel:

First, we estimate that in 2009 Medicare pays $122 billion more in Medicare Advantage plans than it would if it were fee-for-service Medicare.

Second: Current high payments have resulted in some plans that bring no innovation but simply mimic fee-for-service Medicare at a much higher cost to the program.

In other words, they are saying that Medicare Advantage plans get paid for a lot more but with no innovation compared to the fee-for-service Medicare. MedPAC says:

This situation is unfair to taxpayers and beneficiaries not enrolled in Medicare Advantage who subsidize the higher costs.

Well, that is pretty obvious. In addition, MedPAC goes on to say:

The excessive payments encourage inefficient plans to enter the program, further raising costs to Medicare.

There are so many dollars currently given to Medicare Advantage plans, according to MedPAC, that encourages inefficient plans to enter the program. Why not? They are getting all of this extra money.

Further quoting:
CONGRESSIONAL RECORD — SENATE

December 4, 2009

The cost of Medicare Advantage subsidies is borne by taxpayers who finance the Medicare program and by all Medicare beneficiaries via Part B premiums.

Or to say it differently, about 78 percent of Americans who are not in Medicare Advantage plans are paying, in effect, a $90-per-year tax for which they get no benefit which goes into the Medicare Advantage plans.

In addition:

The Part B premium for all beneficiaries is increased by about $3 a month, regardless of whether you receive the benefit.

A couple of more quotes from MedPAC:

The additional Medicare Advantage payments have hastened the insolvency of the Medicare Part A trust fund by 18 months.

That is an interesting statement.

The additional payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

Going with quotes from MedPAC:

Although many plans are available, only some are of high quality.

In addition, continuing the quote:

Only about half of the beneficiaries nationwide have access to a plan that CMS rates as above average in overall plan quality.

That is what MedPAC says. That is the nonpartisan expert that helps advise Congress on what reimbursement levels should be.

We have heard day after day that this bill is cutting Medicare benefits for our seniors. When my colleagues on the other side of the aisle realized this bill does not cut, reduce, ration, or eliminate a single guaranteed benefit, they turned their argument to Medicare Advantage. I think they finally recognize there are no guaranteed benefits cut in this legislation, so they turn to Medicare Advantage. They argue that the efficiencies and savings achieved by ending billions of dollars of overpayments to these private plans will either end the program or dramatically reduce beneficiaries.

But let’s just look at the numbers. I have a chart behind me. This chart shows the yearly spending for Medicare Advantage in billions of dollars. So you can see from the chart that in the year 2009, $110 billion will be spent on Medicare Advantage plans. That is the far left. Moving to the right, 10 years later, in the year 2019, about $204 billion is spent. So if we total it all up, about $1.7 trillion will be spent on Medicare Advantage plans over the next 10 years.

You see that little—what color is that? It is kind of orange, it is kind of an interesting sort of red—whatever it is, at the top of that chart. That represents the reduction in Medicare Advantage plan payments under this legislation. It is not very much, as you can tell by looking at the chart. It averages out, I think, to around a 10-percent reduction in Medicare Advantage payments.

So I encourage us to keep in mind, when we hear all of these dramatic statements that so much is going to be taken away from seniors because Congress is cutting Medicare Advantage, the fact is, we are reducing the rate of increase in Medicare Advantage payments by only about 10 percent, and under this legislation about $1.7 trillion will be spent on Medicare Advantage plans.

Remember, MedPAC says these are overpayments. MedPAC says this 10 percent reduction is what they should be paid.

Remember, too, these are private plans. These are private companies. It is not Medicare Advantage companies receiving these payments, and they are insurance companies. It is interesting to me that a lot of Members of Congress aren’t too wild about insurance companies. Well, Medicare Advantage companies are insurance companies. That is what they are. They are private insurance companies. They have their private insurance company chief executive. They have their private insurance company officers. They have their private insurance company stockholders. They have their private insurance company administrative costs and marketing expenses. They are private insurance companies. That is what they are. So we should not lose sight of that.

I wish to also point out that as private insurance companies, these Medicare Advantage plans are doing pretty well. Let me quote from an Oppenheimer Capital analyst in a November 12 report about Medicare Advantage plans. He said:

Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains of nearly $500 million.

Commercial risk earnings gains are the ordinary earnings companies, but 75 percent of the gross profit increase was under Medicare Advantage plans, not traditional health insurance.

I might say, too—I don’t have the papers; maybe I can find them. It is worth noting, it underlines the point that these are private companies. It is not traditional Medicare.

Here it is. Because it is interesting, let’s look at the compensation of these insurance company executives of these Medicare Advantage plans, the CEOs.

The total compensation of a CEO at Aetna is $24 million a year. The total compensation of the CEO at Coventry is $9 million a year; at Wellcare, $8 million; at Humana, $4.7 million a year; and at United Health Care, $3 million. Now, people should be able to make some money and officers of companies should be able to do OK, but here we are talking about very high salaries in these insurance companies pay to their top executives. Frankly, if there is a 10-percent reduction in the $1.7 trillion over 10 years, they could, you would think, take some of that 10 percent maybe in salary reduction or dividends to stockholders, make other cost savings. It doesn’t have to come out of the beneficiaries. It is they, the executives, who are making these decisions of where the 10-percent reduction is allocated.

But to be clear, I just wish to say I am not opposed to Medicare Advantage plans. Frankly, I think it is good we have Medicare Advantage plans. Medicare Advantage plans provide the competition to Medicare. They help keep the system on its toes. But we have an obligation as Members of Congress to examine this plan to the taxpayers and to seniors to cut waste and to cut overpayments in a way that does not harm beneficiaries.

These are reductions recommended to Congress by the best advisory board of experts we could find. They didn’t just come out of thin air and Members of Congress thought this up. This was recommended to us by the MedPAC advisory board.

Second, there is no reduction in guaranteed benefits to seniors. That is absolute. There is no reduction in guaranteed benefits to Medicare Advantage participants. So A, we are being fair. This chart shows it. We are trying to find the right level of reimbursement set up in a way so there is no reduction in beneficiaries’ benefits. In fact, in this legislation, we add more benefits for Medicare participants, Medicare Advantage, as well as traditional fee-for-service Medicare. I might add in this legislation we give an increase to Medicare Advantage plans that show demonstrated improvement in quality.

As I mentioned, MedPAC said a lot of these plans are totally inefficient. A lot of these plans have no coordinated care. A lot of these plans don’t have any quality, but they get the extra money. So we are saying let’s get to a compensation level that is fair. We do it on a competitive bidding basis, take the average bid for an area, and we also say let’s make sure there is no reduction in guaranteed benefits at the same time. I think that is a responsible thing to do.

So all of these arguments, these sound bites, frankly, that you hear from the other side of the aisle are just that, they are sound bites. They are not the honest analysis of what is going on.

So I encourage us to keep in mind, keep in perspective what we are doing so we can help provide a better health care system for our country. This is only one part of it. There are many other parts, but this is just this one part.

How much time do we have remaining, Mr. President?

The PRESIDING OFFICER. There are 13½ minutes.

Mr. BAUCUS. I see Senator Dodd is on the floor. At this time I yield to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, first, I wish to thank our distinguished chairman of the Finance Committee.
for debunking what has just been said on the Senate floor by our colleagues on the other side of the aisle, laying out the facts of what is and is not happening with Medicare Advantage. I wish to build on that as well.

We heard from someone who is interested to go to the Web site of AARP, one of the organizations we know to be champions for seniors, and take a look at what they say about the myth that health care reform will hurt Medicare. They lay out several things. One is:

None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

Then, just this week, in supporting our efforts, they have put out a statement, a letter, and at the end, again, they reiterated:

Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

I find it interesting that a few years ago our colleagues quoted AARP all the time and time again to protect the for-profit insurance industry that right now is receiving overpayments. Whether it is the CBO or MedPAC—any analysis will say they are receiving overpayments right now, and we are trying to ratchet that back.

What is really wrong is that folks care? Of course, taxpayers care about overpayments. We have maybe 15 to 20 percent of seniors right now who are in the Medicare Advantage Program. We have been told by the Budget Office that they will see their premiums go up for overpayments to for-profit insurance companies. That is not fair. The vast majority of seniors and people with disabilities would see their premiums go up under Medicare to pay for for-profit insurance companies that try to get a piece of the action under Medicare.

Secondly, we know the Medicare Advantage Program, as the chairman has said, and in reading the report, has actually made the solvency of the Medicare Advantage Program less likely to last out of money sooner if we don’t stop these overpayments. Our legislation, rather than having it run out of money 18 months earlier, will increase the solvency by 5 years. We are committed to increasing the solvency of the trust fund and protecting Medicare for the future. We believe it is a great American success story. We are proud that Democrats were the ones who created Medicare, with a Democratic President. We are proud that it was Democrats now who are coming forward to be able to make sure we protect Medicare for the future.

What is happening here is that we are seeing a variety of stalling tactics, a variety of efforts on the other side not only to stop us from moving forward on health insurance reform, but efforts time and time again to protect the for-profit insurance companies.

For the record, I want to read to you the list of the hundreds of millions of dollars that everyone receives now, which will continue regardless of this—whether we cut back on some of the profits of the for-profit insurance companies: inpatient hospital care and nurses; doctor office visits; laboratory tests and preventive screenings; skilled nursing; hospice care; home health care; prescription drugs; ambulance services; durable medical equipment, such as wheelchairs; emergency room care; kidney dialysis; home health care; occupational physical therapy imaging, such as x rays, CT scans, and so forth; organ transplants, and a “welcome to Medicare” physical.

They are all covered now and will be covered under this legislation. The difference is we are going to take the overpayment to the for-profit insurance companies and put it back into Medicare to reduce the cost of prescription drugs, which has become the infamous doughnut hole, the gap in coverage. We are going to by taking the excess profit for the for-profit companies and putting it back into Medicare. We are going to reduce the premiums seniors pay for drugs and medical care and eliminate copays so that people can get preventive care without a fee, and we are going to strengthen Medicare for the future.

I will wrap up by saying this: This legislation, in total, is about saving lives, about saving money, and about saving Medicare. We admit our goal is not to save the profits of the for-profit insurance companies. We are guilty of that. We are focused on making sure Medicare is strong, vital, and solvent for our future generations, as well as our seniors today. By the way, we are going to make sure we are saving lives and money in the process.

I strongly urge us to support any effort that is put forward that would be done in the interest of the insurance industry and at the expense of seniors in America. That is what these efforts to commit are all about. I hope we will do the right thing.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, let me, first of all, commend our colleague from Michigan, who’s on the Finance Committee and has been a stalwart defender of the traditional Medicare Program and of our elderly not only in her State but around the country. She has offered, I think, some very important and worthwhile information this morning once again on this subject matter.

We keep going around and around in this debate. It is a little frustrating because we are talking about basically whether we are going to be able to some degree the profits of some private insurance companies that are under the rubric of something called Medicare Advantage. Again, these are private companies that are receiving subsidies, supported by Medicare beneficiaries and the taxpayers of this country. We are not talking about eliminating Medicare Advantage but rather—we had a big chart a few minutes ago. We will get it in a few minutes. It shows that not eliminating the program, we are restraining profit growth in the program.

We are rewarding Medicare Advantage in the bill, as the chairman pointed out. Based on performance and quality, we actually give bonuses in Medicare Advantage—contrary to the arguments you have heard by those who are heralding Medicare Advantage, despite the fact that the very companies who have been promised they were going to prove how they could reduce costs and be more efficient. In fact, today, it is quite the opposite. Right now the government pays these Medicare Advantage insurance companies $23 billion a year, and the cost for seniors that Medicare does for $1. That is basically, on average, what it amounts to.

The question is, can we reduce the cost of the overpayments, which are basically ending up in the pockets of insurance companies? There is nothing wrong with profits in private companies, but let’s declare them what they
are. This is not traditional Medicare. They are private companies that are anxious not only, I presume, to provide benefits to their beneficiaries, but they are also looking to make a profit. There is nothing wrong with that, but since the premiums were set by statute, the obligation to try to keep our costs down, we are trying to do so because the promises that were made have not been kept. The costs are vastly exceeding the promises made.

The amendment we are going to hear about from our friends on the other side is nothing more than a recycled compilation of some of the "greatest hits" we have heard: stalling with arcane obstruction tactics, while standing up for some of the private companies—and I have no objection to standing up for private companies that do a good job, but when you do so at the expense of scaring seniors with baseless claims, then I do object. That is what is going on here, quite frankly. Today almost 80 percent of our elderly are paying $90 a year in additional premium costs, without getting any benefit from it whatsoever, to provide benefits under the Medicare Advantage Program. That is not equitable. The 80 percent of our elderly need to know that they are being disadvantaged by this.

What the Finance Committee, under the leadership of MAX BAUCUS, is trying to do is bring some equity back into this. He pointed out—and it deserves being repeated—that nothing in the bill does away with Medicare Advantage. We are trying to get it back to a sense of reality and not, again, disadvantage 80 percent of our seniors.

Right now, there is Medicare "disadvantage"—that is what it ought to be called, because that is what it does—disadvantages. Why should 80 percent of the elderly in this country pay higher premiums, with no benefits, at the expense of the 20 percent who are going to get some small advantage under this—but very little, because most of it ends up in profits. I will tell you why that happens in a minute.

To make my point, according to the Oppenheimer Capital analyst Carl McDonald, in a report issued a month ago:

Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the largest plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains of nearly $600 million.

I know the chairman of the Finance Committee, my colleague, has made so much of the Medicare doughnut hole. That is an added benefit that does not exist today. We reduce premiums to pay for drugs and medical care. We eliminate the copays. What an advantage that is here. Ask yourself whether you would like to eliminate copays or watch private companies make an additional $20 billion in profits? Does it make more sense, in my view, to get rid of the drug copays? Ms. CLEARANCE did a study, and I think it is an important one. She did a study in 2003 and 2004 on the Medicare Advantage plans. She found that 80 percent of patients who were switched out of the Medicare Advantage plans had a rise in their drug costs. Of course, she did not study traditional Medicare. That is what is going on here because, quite frankly, in the Medicare Advantage Program, we are paying $90 a year in additional premium costs, without getting any benefit from it whatsoever, to provide benefits under the Medicare Advantage Program. That is not equitable. The 80 percent of our elderly need to know that they are being disadvantaged by this.

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life-threatening reaction to one of the medications from which she almost died. The Medicare Advantage plan denied coverage for all of this care because it was out of network. She was in Utah. They said no, leaving the client and her husband with $50,000 in bills. Again, the Center for Medicare Advocacy went to court and battled against this decision. They were successful in recovering $90,000 out of the $100,000. This woman is now deceased, but she and her family were left with over $10,000, which would have been covered under traditional Medicare, but she had gone into a Medicare Advantage plan. In both instances, they would have avoided having to go to Federal court, having to fight as hard as they did, going through the trauma and turmoil. It is bad enough you have to wrestle with cancer or wrestle with a brain tumor, but then you get saddled with $100,000 in bills and Medicare would have taken care of them. This Medicare Advantage Programgram disadvantaged her in the process.

These are examples of how private Medicare Advantage does not always operate in good faith. They are not always there when you need them.

There are significant differences between Medicare Advantage and Medicare. With traditional Medicare, you know what services you get.

I ask unanimous consent to have printed in the RECORD a list of services so people can read about it. If people have not already done that.

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

No one is removing Medicare benefits. Every senior in America will still get these benefits: Inpatient Hospital Care and Nurses; Doctor’s Office Visits; Laboratory Tests and Preventive Screenings; Prescription Drugs; Ambulance Services; Durable Medical Equipment; Home Health Care; Kidney Dialysis; Outpatient Mental Health Care; Occupational and Physical Therapy; Imaging (X-rays, CTs, and EKGs); Organ Transplants; and “Welcome to MediCare” Physical.

And under our legislation: Reduces the Size of the Medicare “Donut Hole”; Reduces premiums seniors pay for drugs and medical care; Eliminates copays; and Helps keep Medicare solvent.

Mr. DODD. Mr. President, all medical necessity hospital care and doctor office visits are covered under Medicare. You know you can get these services from any Medicare provider anywhere in the country. Out of network you get this kind of help, whether you are in Utah, Florida, or Vernon, CT, where one woman was from. Medicare provided the bills. Here she was bouncing around the country and denied one place after another under Medicare Advantage. With traditional Medicare, she would not have had to worry about a private insurance plan playing games with her coverage.

The Medicare Advantage plans run the show. They change the benefits. Cost sharing goes on. This is why Medicare Advantage is not like traditional Medicare. So when people say it is just like Medicare, no, it is not just like Medicare. If you doubt me, then call that family in Madison, CT, or call that woman’s family from Vernon, CT. Ask them whether Medicare Advantage is just like Medicare. We will get an earful from them on what they went through.

We should be clear that we are not eliminating Medicare Advantage. Again, I appreciate Senator BAUCUS’s amendment because he made a decision over and over again. We are not eliminating it at all. We are reducing payments to private plans and making the system work more uniformly. We actually give bonus payments for care coordination and quality improvements. These plans can use those payments to improve benefits for beneficiaries. So we are hardly eliminating it. We are making it work better.

I have serious reservations about how this plan works. I will say that, but I would not advocate on the floor of the Senate the elimination of Medicare Advantage. I do want to make it work better, and I do want to cut back when we have overpayments occurring. I don’t think it is fair that 80 percent of the seniors in my State or elsewhere are paying $90 a year extra to cover this program and get none of the help from it and people under Medicare Advantage, who could have been protected, are not because they opted to be in that plan and then found out it is anything but what they thought it was.

We are going to hear these arguments over and over about Medicare Advantage. A little truth in advertising is necessary here. So people understand, it is not Medicare and it is not an advantage, not under the present system, not at all. That is what we have been trying to say over and over again here so people understand.

This is the reality of this bill. This took a tremendous amount of work in the Finance Committee, which had the responsibility of drafting these provisions which are highly complicated and very delicate in what they do. What we have done is preserve and strengthen our Medicare system, expanding benefits for people, eliminating copays, allowing those preventive and screening services to be available to our elderly, seeing to it they will have prescription drugs at lower costs. That is all in this bill. That is a great advantage.

What a tragedy it would be if in these next few days, after all the debate, that we lose all the work that has been done to make these improvements in our health care system.

I commend my colleague from Montana and my colleagues on the committee who worked so hard to put this bill together, this balance together that can make a great difference in people’s lives.

I also thank my colleague from Rhode Island for offering his amendment, which we are going to be considering at some point when we get to vote occasionally on some matters here. I hope at some point we get to do that. We have done it a couple of times. There has been over a year of debate and discussion. I think the American people want to see this happen.

We think we have a good bill. It is going to take on important market insurance reforms that ensure Americans can get access to health care promised by their insurance plans. It is going to make sure if someone loses his or her job, they can get insurance. And we are going to discuss how to improve the quality of health care and focus our system more on prevention and wellness.

On top of all these things, it is going to reduce the deficit. As we have heard over and over again, CBO is talking about saving $130 billion in the first 10 years and $650 billion in the second.

I have to say something. The other day we got the news that CBO said the premiums on the individual plans, the small business plans, business plans, are actually going to reduce premiums costs by as much as 20 percent in one area, and 3 percent in another. I would have thought there would be wild applause. Even those opposed to the legislation said: Isn’t this great news? What we got was almost a deep disappointment that CBO gave us a report that people are actually going to save money under this bill. All of a sudden they attacked CBO because they did not like the results coming out of CBO. I guarantee had they come back and said they are going to increase premiums, we all would be talking about that. Here we get a report that actually we are going to save premium costs, reduce the costs to the Federal budget as has been pointed out.

Senator WHITEHOUSE is going to offer an amendment that makes clear these savings we are talking about are used to reduce the deficit, and contribute to the long-term solvency of the CLASS Act, that it will be for that purpose and that purpose alone.

The third part of his amendment is particularly important. Many of our colleagues have come to the floor in the last few days to claim the CLASS Act will be a long-term drain on the budget. It is not true. Thanks to our colleague from New Hampshire, Senator GREGG, the CLASS Act will be re-requiring Senate the elimination of Medicare Advantage. I will say that, but I would not advocate on the floor of the Senate for the Federal Government over the

We have included language to prevent making it work better. The Gregg amendment was unanimously adopted in our markup. CBO says it produces $72 billion in savings for the Federal Government over the first 10 years of its existence and it will save nearly $2 billion for Medicaid.

We further added language to the bill to require the Secretary to maintain enough reserves after the first 10 years to pay off any claims that may emerge. We have included language to prevent

December 4, 2009

CONGRESSIONAL RECORD — SENATE

S12375
Federal appropriations from being used to pay benefits to ensure the program is self-funded.

Finally, at the request of several Senators, the distinguished majority leader made sure we did not use any of the funds in the CLASS Act for any other purpose than to pay for the CLASS Act itself. This amendment offered by Senator WHITEHOUSE will give Senators a chance to commit themselves to that purpose. Senators who claim the CLASS Act will hurt the Federal budget, course, should vote for this amendment because statutorily it will prohibit any of those funds from being used for any other purpose other than for the CLASS Act and the recipients who want to use them. I commend him for that move and thank him. When that vote occurs, I urge colleagues to vote for the Whitehouse amendment.

Lastly, I ask unanimous consent to be included as a cosponsor, along with my colleague from Maryland, Senator COBURN's amendment No. 2789 which adds Members of Congress to the public option. The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I wish to speak. Senator Coburn offered that amendment. Senator Kennedy, myself, and others voted for that Coburn amendment. I think it may have shocked the Senator from Oklahoma at the time that we actually voted for his amendment. I know Senator BROWN has been added as a cosponsor. I have no objection to that amendment. That is how much I think the public option would be worth. If we have a public option in this plan—and my hope is we will—there is nothing wrong with insisting Members of Congress be included in that public option proposal. His amendment suggests that. We supported it in committee, and I am prepared to support it again on the floor of the Senate.

I point out, I wish we could get Members as well who are reluctant to support this bill to recognize that as Members of Congress today, we all have pretty good health care plans under the Federal employees benefits package, some 23 options every year that are available to us, along with the 8 million Federal employees in this country under those plans. I wish we could get other States to authorize how valuable that is to all of us and our fellow Federal employees. Unfortunately, that does not seem to be the case.

I hope before this is concluded we will have far more support for this effort we have crafted and passed to our colleagues for their consideration.

Again I compliment the Finance Committee and my friend from Montana for the work he has done on this issue. It is very well thought out, very balanced and fair.

I said this over and over: I challenge any Member to come to the floor and identify a single guaranteed benefit under Medicare that is cut out under this bill. There is not one. Three days have gone by since I made the charge that not a single guaranteed benefit under Medicare is cut. You will not find one; not one.

I see my friend from Wyoming has come to the floor. I know I have probably gone over my time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are playing things by ear. I ask unanimous consent that the Senator from Wyoming be recognized to speak for debate only, and at a later point, we will figure out allocation of time on both sides, if he wishes to speak now. Senator ENZI. Yes, Mr. President, I wish to speak.

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

Mr. ENZI. Mr. President, it is my understanding that it would be in charge of the next 30 minutes and then it would revert to the other side for 30 minutes after that. Mr. BAUCUS. I might modify that so this side gets the next 30 minutes after that.

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

Mr. ENZI. It is also my understanding that at any time there is an agreement to vote, we will cancel out what we are doing. But there is no agreement yet.

I thank the Senator from Connecticut for setting up my speech so well. He said there was not anywhere that anybody can show any decline in guaranteed benefits. With what I am about to say, I will try to do that. Of course, the words “guaranteed benefits” do not show up anywhere in what we are doing. “Benefits” does but not “guaranteed benefits.” In my opinion, getting to be in a nursing home or being able to see a doctor; some of those ought to be considered guaranteed benefits. I will get into that a little bit in my speech and cover some of these areas that I think are very important to seniors. I am opposed to the $5 trillion of Medicare cuts in the Reid bill that are not going only to solve Medicare.

Some of my Democratic colleagues have attempted to argue this bill does not cut or reduce any guaranteed Medicare benefits. They have attempted to further said that will not harm the program. They have also argued that no beneficiaries will lose their benefits—guaranteed benefits. They are very careful on that, and I understand why they are careful on that because there are other benefits that are being cut that will be considered by those people who will lose that benefit to be a guaranteed benefit.

Unfortunately, all of those statements are false. It does not matter how many times my colleagues repeat these claims, they do not become any more accurate. This bill cuts $464 billion from the Medicare Program. It slashes payments to hospitals, nursing homes, home health agencies, and hospices. These are cuts to the Medicare Program, and I even have the page numbers on those.

The moneys from these cuts do not go to shore up Medicare. The money goes to new programs for others. These cuts will affect the care provided to Medicare beneficiaries.

The American Health Care Association, which represents nursing homes, said the cuts in the Reid bill would force layoffs, lower salaries, reduce benefits, and ultimately would hurt patients’ quality of care. A commission was set up to make even more cuts to save Medicare. It is in the bill. There is a commission in there.

So with the side deals that have been made with lobbyists, the only place these cuts can come from is from seniors. I will cover that in a little more detail later. I have heard similar statements from home health providers, that is more than $40 billion in cuts; hospice providers, which is $8 billion in cuts; and hospitals, which is $130 billion in cuts. These Medicare cuts go into effect, it could drive providers out of the Medicare Program. That will mean patients do not have the care they expect and need.

Some of my Democratic colleagues have accused us of trying to scare Medicare beneficiaries. If seniors are scared by our statements, they should be terrified by what the administration has to say about the Democrats’ health reform bill. The administration’s own chief actuary, Richard Foster, recently wrote that the steep Medicare cuts in the House-passed health reform bill would make it difficult for many providers to remain profitable and cause them to end their participation in Medicare. I want to note this could jeopardize Medicare beneficiaries’ access to care.

As the senior Senator from Tennessee noted yesterday, it is the Medicare cuts in the Reid bill that are actually cutting seniors’ benefits. The Administration’s chief actuary, Richard Foster, recently wrote that the steep Medicare cuts in the House-passed health reform bill would make it difficult for many providers to remain profitable and cause them to end their participation in Medicare. The President said the cuts in the Reid bill would not affect Medicare. The administration’s own chief actuary, Richard Foster, recently wrote that the steep Medicare cuts in the House-passed health reform bill would make it difficult for many providers to remain profitable and cause them to end their participation in Medicare.

The chairman of the Finance Committee has repeatedly said this bill will not cut or reduce any guaranteed Medicare benefit. That statement seems to be far from the truth. Some beneficiaries understand that if providers are no longer able to take Medicare patients, they—the seniors—will not get care. A lot of grandmas and grandpas have figured it out, and they are not going to stand for it.

The chairman of the Finance Committee has repeatedly said this bill will not cut or reduce any guaranteed Medicare benefit. The statement seems to be far from the truth. Some beneficiaries understand that if providers are no longer able to take Medicare patients, they—the seniors—will not get care. A lot of grandmas and grandpas have figured it out, and they are not going to stand for it.
So let’s see, $464 billion in Medicare money we are using on other things. That is why I keep saying Medicare money only ought to go to Medicare benefits, and that $250 billion for the doctors’ fix might make it possible for people to see the doctors. I think the reason why doctors want to fix this flawed government price-control system—and that is what it is because they are telling the doctors what they can charge a customer, regardless of how long a time it is going to take them to get a patient. For a lot of them, they have discovered it costs more than what they are able to get. If they continue to do that, they have to go out of business. That is kind of the small business philosophy: You take in less money than what it costs to be in business, and you are out of business. So I don’t think they like that kind of a government price-control system.

As a result, 40 percent of the doctors will not take a patient on Medicaid, and it is growing in percentage now on Medicare in the same way. When you fix the price, some people can’t afford to provide it for that, so they can’t take those patients.

I was talking to a friend of mine from Florida who said: Every time you call a doctor now, they say: Are you on Medicare? If you say yes, they say: We are not taking any new patients. If you can’t get a doctor, you don’t have a benefit. It shows the exact problems that result from letting government bureaucrats use price controls to set payment rates. What I don’t understand is why the AMA continues to support the bill when they got nothing for their deal. We didn’t fix the $250 billion problem, and we haven’t fixed the junk lawsuit problem.

I remember the President appearing at the National Convention of the American Medical Association and promising the country that there would be major health care reform; that there would be an end to these junk lawsuits. All of our attempts, either in the HELP Committee or in the Finance Committee, to even bring that up have been either voted down or denied. As a result, there is nothing in this bill that is going to solve that problem. The bill does nothing to fix the Medicare payment formula for doctors. Instead, it cuts $464 billion from Medicare and uses that money to cover the uninsured.

Even worse, without hurting seniors, the Republicans are saying: Use the money only for Medicare. Medicare money for Medicare, Medicare funds should be used to fix Medicare’s problems, such as this flawed payment formula that keeps doctors from taking seniors. Taking hundreds of billions of dollars out of the Medicare Program now will only guarantee that it will be much harder to permanently fix the doctor payment issue in the future.

I cannot understand why the AMA continues to support this terrible deal for doctors. If you can’t see a doctor, your benefits—your guaranteed benefits—have been cut. Apparently, the members of the AMA don’t like the deal either. At a recent convention, up to 40 percent of the current membership of the AMA voted to reject this deal. I know that is not a majority, but many associations have consensus agreements. That means almost all of their membership agrees with the tack they are taking, not just slightly more than half. Their membership is less than 20 percent of all doctors. It is a deal based on consensus agreements.

Let’s see, less than 20 percent of the doctors had 40 percent that opposed it. We are getting down to some pretty small percentages of those who supported what the AMA did in their deal.

Finally, many provider groups have been reluctant to speak out against this bill because they have received threats from the White House and congress. Senior living facilities, home health agencies, and hospice providers have all reportedly been threatened with further cuts—further cuts—if they speak out against the bill. Is that freedom of speech, or is it just bad ethics? They have reportedly been told that any public statements of opposition to the Reid bill will lead to even more severe cuts.

These providers have had the chance to silently accept devastating cuts rather than oppose them and risk being utterly destroyed. One of the Medicare Advantage providers is Humana, and I will use them as an example. CMS said they couldn’t let their enrollees know what was about to happen, and chasitized them for sending out a letter. I thought the customer deserved to know and that we were in a new era of transparency. That doesn’t sound very transparent to me. So how can that happen in America?

At any rate, I hope my colleagues and the American people will take these facts into account when they hear Senators talk about provider groups supporting this bill. Unfortunately, health care support for this bill is being driven primarily by greed or stupidity or fear. We know this bill will not fix the problems in the American health care system. It will not lower health care costs. It will not lower insurance premiums. It will still leave 25 million people uninsured.

What this bill will do is spend $2.5 trillion and guarantee a much bigger role for the government in dictating how health care will be treated in this country. If you are not under Medicare, yes, your government is going to tell you what is adequate coverage, and they are going to force you to buy it or pay a penalty.

Even recent experiences that doctors have had with Medicare price controls, this is not an outcome that bodes well for America’s health care providers or their patients. I remind everybody that in August there was an upsurge, and that upsurge continues. We don’t notice it as much because we are not going to get to go home this weekend to talk to our constituents. That
might be by design because we already know what our constituents are saying. They are saying: This bill is a bad deal for us. Where is the promise that you were going to cut costs for us? Where are the other promises that were made with care reform that will be on the average, but under this health care bill it should jump to $15,200. That is not very good news for the people in my State or any other State. No big cost rise in U.S. premiums is seen in the study, said the New York Times.

The Washington Post declared: Senate health bill gets a boost. The White House crowed that the CBO report was more good news about what reform will mean for families struggling to keep up with skyrocketing premiums under the broken status quo. The Finance chairman, the Senator from Montana, chimed in from the Senate floor that health care reform was fundamentally about lowering health care costs.

"Yes, lowering costs is what health care reform is designed to do—lowering costs. But then he said: And it will achieve this objective. Except that it won't."

CBO says it expects employer-sponsored insurance costs to remain roughly in line with the status quo. That is the failure of this bill. Meanwhile, fixing the individual market is expensive and unstable, largely because it does not enjoy the favorable tax treatment given to job-based coverage. You know, if you are buying insurance on your own, you are not getting a tax break on it. If companies buy insurance for the people working for them, they are getting a tax break.

In my 10 steps to solving health care, I mentioned work control on making that fair. You have to be fair for both sides.

The Wyden-Bennett bill concentrates on making it fair for both sides. That is one of the issues people in this country are concerned about, making it fair for both sides. This bill doesn’t make it fair for both sides.

Talking about fixing the individual market, that is expensive and it is largely unstable, I will say again, due to the treatment of job-based coverage which was supposed to be the purpose of reform. But CBO is confirming that new coverage mandates will drive premiums higher.

Democrats are declaring victory, claiming these high insurance prices don’t count because they will be offset by new government subsidies. About 57 percent of the people who buy insurance through the bill’s new exchanges that will supplant today’s individual market will qualify for subsidies that cover more than half the total premium so the bill will increase cost but then disguise those costs by transferring them to taxpayers from individual mandates. Higher costs can be conjured away because they are suddenly on the government balance sheet.

The Reid bill has $317.9 billion in new health taxes that are apparently not a new cost because they would be passed along to the employers they will be hidden in lost wages. This is the paleoliberal school of brute force wealth, redistribution and a very long way from the repeated White House claims that reform is all about bending the cost curve. The only thing being bent here is the budget truth.

Moreover, CBO is almost certainly underestimating the cost increases. Based on its county-by-county actuarial data, the insurer WellPoint has calculated that this bill will cause some premiums to triple in the individual market. I don’t go by WellPoint, I go by what I found out in Wyoming itself and that is an accurate picture, particularly for the young people in our State. Those who are young and healthy are saying: This is not fair. That is why today some 35 States impose no limits on premium variation and 6 allow wide differences among consumers.

That is not just WellPoint that is saying that. I have some peer-reviewed documents that also show that same thing from people from different colleges. They have found that the State community rating laws raise premiums in the individual market by 21 percent to 32 percent across the States and 9 to 17 percent for singles. In New Jersey, which also requires the insurers to accept all comers, so-called guaranteed issue, premiums increased by as much as 227 percent.

"Let’s see, we just had some elections in New Jersey and things didn’t go well there. It probably wasn’t just tied to insurance costs."

"The political tragedy is that there are plenty of reform alternatives that would be more effective. According to CBO, according to the Congressional Budget Office which we quote a lot, they did an evaluation on the relatively modest House GOP bill. The Republicans in the House were limited to one amendment. There were three amendments total in a 1-day debate and passage of the health care bill over there. That roused a lot of people in America, too. If you only get one amendment, they had to do what we have avoided doing. We have four different options here. Or perhaps they are the ones upset about what is happening and it is easy to see why. Even though the AARP says this is a good bill, they are saying: Wait a minute. I know people in the nursing home. I know people—some of them are saying I am in the nursing home. Am I hearing what is going to happen at my nursing home if these cuts go into place.

As I read this, it says the Republicans tried to keep the Medicare money for people on Medicare, but the Democrats want to take $460 billion away from seniors who depended upon Medicare and use it to start a whole new government program. Am I reading this correctly?"

Mr. ENZI. That is the way I read it. That is the way the people in Wyoming are reading it and that is apparently the way people all over the country are reading it, particularly seniors. Seniors are the ones upset about what is happening and it is easy to see why. Even though the AARP says this is a good bill, they are saying: Wait a minute. I know people in the nursing home. I know people—some of them are saying I am in the nursing home. Am I hearing what is going to happen at my nursing home if these cuts go into place.

As I said continually, we can call them anything we want but the seniors are saying those are cuts. Those are new cuts in what I expect. Those are cuts in what I have been getting. Whether you call it guaranteed benefit or just plain old...
benefits or whatever it is, they are saying, yes, we are being cut.

Mr. Barrasso. Mr. President, I would say when my colleague from Wyoming and I hold townhall meetings around the State of Wyoming, people have one question in mind. What I see this bill doing is cutting our Medicare and specifically, right now, there are thousands of people in Wyoming who are on a program called Medicare Advantage. There is an advantage program. That is why so many Americans have signed up for the program.

As a matter of fact, about one in four Americans who depend upon Medicare for their health care in this country has chosen Medicare Advantage, because there are some advantages being in this program called Medicare Advantage: dental, vision, hearing, fitness. Also, as a practicing doctor for 25 years, taking care of families coming, what I saw, the reason they liked this, if they were on Medicare, is because it dealt with prevention and it actually helped coordinate care.

One of the things Medicare does not do as a socialized care and work prevention. We know how important prevention is in helping people keep down the cost of their care—how good it is in terms of giving people opportunities to stay healthy. That is why the call it prevention.

The bill in front of us, as I see it—I ask the Senator from Wyoming—is a bill that is going to cut $250 billion from Medicare Advantage, the program the people across America have figured out that Medicare doesn’t have catastrophic coverage. But Medicare Advantage provides catastrophic coverage as well. A number of other things that Medicare does not cover. I think they realize, too, that if Medicare Advantage goes away, yes, they can get Medigap but Medigap is more expensive. It is also interesting that the AARP sells Medigap.

Mr. Enzi. The Senator from Wyoming is absolutely correct. We are getting a lot of calls and mail, letters about that. Another thing the President promised, of course, is that everybody above the age of 55 will get a base of catastrophic coverage. It fascinates me that the Wyoming people and the people across America have figured out that Medicare doesn’t have catastrophic coverage. But Medicare Advantage provides catastrophic coverage as well. A number of other things that Medicare does not cover. I think they realize, too, that if Medicare Advantage goes away, yes, they can get Medigap but Medigap is more expensive. It is also interesting that the AARP sells Medigap.

Mr. Barrasso. I actually heard somebody say Medicare Advantage is not Medicare. But if you turn to the Center for Medicare and Medicaid Services or any number of other things that Medicare does not cover. I think they realize, too, that if Medicare Advantage goes away, yes, they can get Medigap but Medigap is more expensive. It is also interesting that the AARP sells Medigap.

Mr. Enzi. I am seeing what you are seeing, and these people do not know what an entitlement actually is. That is a bill that goes on forever. The Secretary of Health and Human Services has to make sure that it is paid in perpetuity unless there is some other provision in action on that. We keep paying that bill over and over again. I think the Senator from Wyoming recognizes entitlements and some of the difficulties involved with that.

Mr. Barrasso. Mr. President, an article in Bloomberg yesterday said the Kaiser Family Foundation poll released this past month found that 60 percent of seniors said they would be better off if Congress did not change the health care system.

We know we need to do some changes. But this massive bill, this 2,000-page bill that weighs 20 pounds, is not the right change we need. For our seniors, people who rely on Medicare for their health, we absolutely cut $464 billion from Medicare. Almost $11 trillion, there is a point where more people—the baby boomers, more and more people are added to the rolls every day. To raid this program to start a whole new government program is not the right prescription for America. It is not what our seniors want. It is not what they signed up for. It is not why they are choosing Medicare Advantage. It is because it is a choice they make and that is why we right now have 11 million Americans who are on Medicare Advantage. We have 11 million seniors—that represents almost one-quarter of all Medicare patients in this country.

Mr. Enzi. We are being notified our time is up. We will continue. I have several letters from Wyoming organizations that I want to have printed in the RECORD, and I will do that at a later time.

I thank the Chair and yield the floor.

Mr. Dodd. Mr. President, a few moments ago I started to describe an amendment that will be offered by our colleague from Rhode Island, Senator Whitehouse, regarding the CLASS Act.

As a bit of background, the CLASS Act is a proposal that was originally conceived by a former colleague and dear friend, Ted Kennedy of Massachusetts, years ago, the idea behind it being that we ought to try to figure out a way to support people in this country who end up with disabilities. Disabilities are not catastrophic, that they would deprive them of the opportunity to continue with work but serious enough that they would require some additional help in order to provide a basic standard-of-living, either a driver, some help on food assistance, whatever it may be.

Under present disability formulas, which are basically income-replacement bills, in order to get some help if you are disabled, you almost have to impoverish yourself to qualify and then be restrained about how much you can actually earn, if you want to continue to work. So while it has been a good program and certainly has helped a lot of people, in a sense with CLASS it is to divert whatever you have acquired or earned and impoverish yourself. Then, even though you may be capable of continuing to work, you are limited on how much you can actually earn under those programs.

It was the vision of Senator Kennedy years ago to try to come up with a different idea, not to replace that but an idea that might allow for people who are unable to get some help during that period of disability, however long it might last, without necessarily having to then impoverish themselves or to limit their outside earnings, given the fact that they may be able to continue to perform and, in fact, would like to continue to work.

The question was, how could we do this, particularly in light of the fact that we don’t want to necessarily be able to afford the cost without having this idea come up with a totally voluntary program that individuals would have to contribute to out of their own pocketbooks, not out of taxpayers’ pocketbooks, by putting aside resources on a monthly basis over a period of years—5 in the case of this bill—where the plan would become vested and then to contribute that amount thereafter. Then, in such case if you found yourself disabled—and there are criteria that would determine whether you met those thresholds—you would then qualify, based on the fact that you have paid your own money into these programs, in order to get some help if you are unable to continue to work. That would provide you with some assistance to you so that you might get along and be able to continue to operate without having to impoverish yourself and put limitations on your work. At $75 a day, that would provide over $27,000 a year for the individual. Again, entirely voluntary, your money, not public money—no taxpayer money goes into the plan.
Five million people under the age of 65 living in the community have long-term care needs, and there are over 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence. Long-term care supports and services are an area that is not currently affordable or accessible for millions of our fellow citizens. It is estimated that 65 percent of all those who are 65 or over today will spend some time at home in need of long-term care services, for which average costs run at least $18,000 a year.

Mr. President, 1½ million people today are in nursing homes, and roughly 9 million of our fellow elderly Americans will need help with activities of daily living during the current year. By the year 2030, that number will increase to 14 million, as we watch the baby boom population age. And while those lives will be extended and hopefully the quality improved, we all accept the notion that as we get older, we have greater needs physically. That certainly is something anyone over the age of 65 can tell you. So as the years progress, the quality of care, longevity table, increases, the number of people who will need long-term care is apt to increase. One more number: Today another will jump from 9 million today to roughly 14 million. Those numbers are apt to increase.

Many people who need long-term services and supports rely on unpaid family and friends to provide that care. They have children or grandchildren who are around to provide that kind of assistance. A lot can’t, of course. But ultimately many of these individuals have to impoverish themselves to qualify for Medicaid. We know what happens. They transfer the house, their assets. They shave everything over to their children or someplace else so that they qualify for that title XIX window. Five million people under the age of 65 living in the community have long-term care needs. Long-term care services at some point in their lives. Beyond that, the CLASS Act would allow a payroll deduction, they would have to find some other way. If the employer decides to offset the cost of assisted living and nursing home care. Let me tell you how the improved version of this act protects the taxpayer. We have heard—there are issues raised about how they are going to be protected under this program. All CLASS Act benefits are paid by voluntary participants, not taxpayers. The CLASS Act actually would save taxpayer dollars by reducing federal costs—according to CBO, almost $2 billion. CLASS Act premiums must be set at a level sufficient to guarantee actuarial soundness of the program.

We thank Senator Gregg for his amendment on the Senate floor on the CLASS Act bill when it came up in committee.

The current CLASS Act includes significant improvements over earlier versions, such as stronger eligibility standards, a new reserve requirement, and an absolute prohibition on the use of taxpayer dollars to pay benefits. The Congressional Budget Office determined that the improved program is totally actuarially sound.

This bill, the Patient Protection and Affordable Care Act, creates a voluntary insurance program. Under the program, working people pay premiums for at least 5 years before it would vest. After that individual has paid in for 5 years and worked for at least 3 of those 5 years and develops a disability, they can receive a cash benefit of no less than $50 a day for as long as that disability persists. Contrary to popular belief, Medicare and most private health insurance only pay for long-term care for a short period, meaning that most people pay out of their own income or assets or their family’s assets to provide this kind of benefit. Those with the most intense needs will frequently exhaust these assets and have to rely on Medicaid, thus impoverishing themselves in order to qualify.

The CLASS Act provides essential options for 65 percent of those age 65 and older who will need long-term care services at some point in their lives and for the 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence.

It has been said that this program is not financially stable and amounts to nothing more than a Ponzi scheme. This program, they say, will create a new government entitlement program. It is not a government entitlement program—anything but. The CLASS Act does not confer rights or an obligation on the government funding, nor does it affect receipt of or eligibility for other benefits. The program stands on its own financial feet.

CBO has estimated the program to be actuarially sound for the next 75 years. The CLASS Act would work only on its own cashflows. CBO estimates an average monthly premium of $123 for an average daily cash benefit of $75 for those who qualify. It may not seem like much, but over a year that would provide needed assistance for those who suffer under disabilities.

CBO uses very conservative participation rates. CBO assumes participation rates that do not consider that CLASS would offer a lifetime cash benefit, endorse enrollment, and provide a convenient way for employees to auto-enroll through their employers with a voluntary opt-out. All of these features would increase participation rates, which will result in lower premiums and encourage enrollment, and make the program even stronger financially.

Solvency of the program is bolstered by flexibility to adjust the program. In their November 25 letter to the Congress, the CBO states that the legislation gives flexibility to the Health and Human Services Secretary to adjust premiums and benefits where or if ever needed. This provides a lever to ensure that the program stays solvent even if real life does not perfectly mirror the models of the CBO, as good as they are.

As the Congressional Budget Office discusses, the CLASS Act would function just like any other private long-term care insurance program. When the premiums exceed the fi

nances benefit payments from a premium reserve and interest income off that reserve. Due to budget scorekeeping, the CBO finds that premium revenue exceeds benefit payments in the third decade but does not take into consideration accumulated reserves and income off those reserves that keep the program fiscally independent.

Beyond being self-supporting and voluntary, this program can actually generate savings in Medicaid. Direct offset of the $75 daily benefit is applied toward any Medicaid long-term care costs. Beyond that, the CLASS Act program will help people live independently at home or in the community. When people with disabilities who need the services they need, they are less likely to spend down to get Medicaid and less likely to enter a nursing home or hospital, all of which generates additional Medicaid savings.

CBO notes that we don’t calculate here, because I don’t know how one would calculate it, is that notion of independence. I suspect maybe all of us
knowledge people who are on Medicaid and know the frustration particularly of someone who is otherwise healthy but suffers from disabilities who would like to work and wants to keep independent. Yet if you go into the Medicaid there are huge constraints on your ability to do so. By this program, aside from financially reducing Medicaid costs, we are actually providing that additional sense of human dignity and decency that just because of a disability and you need help doesn’t mean you don’t want to be self-sufficient and keep working. There is the gratification of knowing you are contributing in some way other than being shuttled away, having impoverished yourself, relying on others’ assets to take care of you because you do not have those resources.

Senator Kennedy generated this idea years ago, and now I think it is improved because of the amendments and ideas that have been suggested by a number of our colleagues here, as well as others, and we have actually strengthened the concept to give it the kind of financial independence Members want it to have, sheltering these dollars against being used for other purposes, going off to the other program that people may have a great desire to fund by tapping into these resources. We prohibit that from happening.

If employers do not want to have a payroll deduction, they do not have to have that. No one is required to join the program. We believe, though, when members of our society and country see the benefits of this, they will gravitate to it as a wonderful way to ensure against that dreaded possibility all of us face: that is, becoming disabled, being unable to work as much as we would like to, needing additional assistance and help, and, of course, having very few places to turn to get it.

The groups and others that support this, 275 organizations, aging, religious groups, disability organizations across the country—I am not going to read all of them here because 275 names is a lot, but I have here the list of all 275 organizations that have strongly supported this proposal. I cannot think of any finer way to celebrate the memory of our former colleague, who cared so much about this bill we are now engaged in debating, who brought this idea to the table years ago, and who championed it for so many years.

Today, we have a chance to include this wonderful concept, this creative, innovative idea. It saves money. It provides independence for people. It gives them a chance to lead good lives. It provides support to their families who otherwise have to bear a lot of that burden. None of us want our children or our grandchildren to have to bear burdens as they are trying to raise their own children. This is a live idea that has generated support, totally by voluntary contributions. There is no government money involved at all. And it is to give people a chance to live out the remaining time of their lives with decency and dignity, having the sense of making a contribution and making a difference.

All of those facts I cannot put a dollar amount on. I cannot tell you what the financial benefit is of someone getting up in the morning, getting a little help but going off to a job and knowing they are needed and have worth and value as a human being. What is the toll of having a division of services for exceptional children. Just for all. Mental Health America, National Academy of Elder Law Attorneys, National Alliance on Mental Illness, National Association for Aerobic Nervosa and Associated Eating Disorders.


AGING GROUPS


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American Hospital Association (AHA), American Mental Health Counselors Association, American Occupational Therapy Association, American Society on Consultant Pharmacists, American Trauma Society, American Association of Amputee Organizations, American Coalition for Health Insurance Reforms, America's Patients, America's Psychia on Children, America's Voice, America's Workforce, Americans United for Separation of Church and State, American College of Obstetricians and Gynecologists, American Dental Education Association, Washington, DC, Asian & Pacific Islander Wellness Center, San Francisco, CA; Association of Nurses in Aids Research, Washington, DC; Association of Nutri- tion Services Agencies (ANSA), Washington, DC; Better Existence with HIV (BEHIV), Chicago, IL; AIDS Services of San Francisco, CA; CAER Foundation, Washington, DC; Catholic Charities CYO, San Francisco, CA; Colorado AIDS Project, Denver, CO; Community Health Board, INC., THECOLORS Organization, Inc., Philadelphia, PA; Common Ground—the Westside HIV Community Center, Santa Monica, CA; Com- munity Services, Inc., Sister District, 150 Liberty St., New York, NY; The Commonwealth Advocates, Inc., Utica, NY; Community Healthcare Network, New York, NY; Community HIV/AIDS Mobi- lization Project (CHAMP), New York, NY & Providence, RI; CREST, Initiative of New England (CRI), Boston, MA; Face to Face/Somona County AIDS Network, Santa Rosa, CA; Fenway Community Health, Boston, MA; Gay Men’s Health Crisis (GMHC), New York, NY; Harlem United Community AIDS Center, New York, NY; Hawaii Island HIV/AIDS Foundation, Kona & Kailua-Kona, HI; HIV Health and Home Support Services, Inc., Newport News, VA; Health Imperatives, Brockton, MA; HIV ACCESS, Alameda County, CA; HIV/AIDS Services for African Americans in Alaska, Anchorage, AK; HIV/AIDS Services/Greater Love Tabernacle Church, Dorchester, MA; HIV/AIDS Support Services, Inc., Newtown, CT; HIV Dis- health and Human Services Planning Coun- cil of New York, New York, NY; HIV Health Services Planning Council, Sacramento, CA; HIV Health Services Planning Council—San Francisco EMA, San Francisco, CA; HIVVitorious, Inc., Madison, WI; HIV Medi- cine Association, Arlington, VA; Housing Works, New York, NY; AIDS Founda- tion, New Brunswick, NJ; Inova Juniper Program, Springfield, VA; JRI Health/Sidney Borum Health Center, Boston, MA; Lanvas Area AIDS Network, Lansing, MI; L.A. Gay & Lesbian Center, Los Angeles, CA; Legacy Community Health Services, Inc., Houston, TX; LifeLinc, Baltimore, MD; Lifelong AIDS Alliance, Seattle, WA; Lower East Side Harm Reduction Center, New York, NY; Michigan Positive Action Coalition (MI-POZ), Detroit, MI; Minnesota AIDS Project, Minneapolis, MN; Nashville CARES, Nashville, TN; National Alliance of State and Territorial AIDS Directors, Wash- ington, DC; National Association of AIDS Service Organizations, Detroit, MI; National Association of People with AIDS, Washington, DC; The National Coalition for LGBTQ Health, Washington, DC; National Mi- nority AIDS Council, Washington, DC; Na- tional Pediatric AIDS Network, Boulder, CO; National Women and AIDS Collective, Brooklyn, NY; National Health and Hospitals Corporation, New York, NY; NYC AIDS Housing Network (NYCAHN), New York, NY; The New York State Nurses Asso- ciation, Latham, NY; New York State Wide Senior Action Council, Inc., Albany, NY; Okaloosa AIDS Support and Informational Services, Inc. (OASIS), Ft. Walton Beach, FL; Open Arms of Minnesota, Minneapolis, MN; Partnership Project, Portland, OR; Paterson Counseling Center, Inc., Paterson, NJ; People Living With HIV/AIDS Com- mittee, Baltimore Planning Council, Baltimore, MD; Positive East Tennesseeans, Knoxville, TN; Project Open Hand, San Francisco, CA; Project Prevent, Project Prevent, Inc., San Francisco, CA; Project REACH, Miami, FL; Ryan White Medical Providers Coalition, Arлин- gton, VA; San Francisco AIDS Foundation, San Francisco, CA; Sisters Together And Reaching Out, Southfield, MI; Southern NH HIV/AIDS Task Force, Nashua, NH; Strong Consulting, Crescent City, CA; Test Positive Aware Network, Chicago, IL; The AIDS Institute, Washington, DC & Tampa, FL; The Albany Damien Center, Al- bany, NY; The International Community of Persons Living with HIV/AIDS, Washing- ington, DC; The Sexuality Information and Education Council of the United States (SIECUS), Washington, DC; The Anaheim Group (TAG), New York, NY; Triad Health Project, Greensboro, NC; United Methodist Mexican-American Ministries, Garden Grove, CA; Visitors and Friends, Boston, MA; Village Care of New York, New York, NY; Wilson Resource Center (WRC), Arnold Park, IA; Women Together for Community Care, U.S. Virgin Islands.

Mr. DODD. I yield the floor.

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

Mr. HARKIN. Mr. President, I wish to thank our friends and leader in this issue, Senator DODD, for his eloquence in supporting what so many of our el- derly in this country want more des- perately than just about anything else; that is, the peace of mind of knowing that if they should become disabled, they will not be forced to go into a nursing home, they will have some sup- port, and they will be able to live in their homes in their communities.

Talk to anyone with a disability—not just the elderly, anyone with a dis- ability—and they will tell you how im- portant it is that you have that kind of assurance that if, God forbid, you become disabled, your only hope will not be to go into a nursing home for the rest of your natural life.

Senator Kennedy worked on this for years. The couple times I talked to him this summer and this spring, this is what he wanted to talk to me about: making sure we included the support in this bill. This was his cause, to make sure we had a program people could con- tribute to that would afford them some support if, in fact, they become dis- abled.

I do not understand the move by my Republican friends to strike this. This is not a mandatory program. This does not force anyone to pay a dime. It is all voluntary. We say, if you want to, you can contribute during your working years in a fund that will vest so that if you become disabled, you can get some support to stay at home, maybe with your own family, maybe with just enough support so you can get another job and work even though you have a disability. This is vol- untary.

I ask my friends on the other side of the aisle, why are you against a vol- untary program that will enable people to have that kind of peace of mind? Well, I have heard it said: Well, maybe the taxpayers will have to pay for this and everything.

I will tell you this: In the committee, Senator Gregg—Senator Gregg from New Hampshire, Republican Senator GREGG, my good friend—offered an amendment to make sure the contribu- tions were the only things that would sustain this program, that it would not become an entitlement. Here is what he said, his own words:

I offered an amendment, which was ulti- mately accepted, that would require that
Senator WHITEHOUSE is suggesting. So again, I think it makes sense to me. So again, I think it has said is, put those savings back in maybe they will get a little bit more for us—is that any savings we get from again, I think this is very appropriate future generations. I'm pleased the HELP amendment. I do not understand why anyone raising more than we can deliver, the program? No one is forced into any- amending more than we can deliver, the program? No one is forced into any- institution if they become disabled. That's why AARP strong- ly supports the Americans with Disabilities Act. There were a few votes against it. In fact, there are one or two people still here who voted against it. I think if you asked them now, they would say it has been a pretty darn good bill. It has broken down a lot of barriers, opened a lot of doors for people with disabilities in our country, changed our environment in this country, not only in terms of physical ac- cess, but I think, more importantly, it has changed how we view people with disabilities, no longer looking at peo- ple with a disability to say, what is their disability, we now look at those people and say, what are your abilities, what can you do—just looking at someone's disability. So we have come a long way.

The only thing we have never been able to really do is to set up a functioning system so people could put some money aside to protect themselves in case they got disabled. Well, this is it. This is our chance. This is a big part of this health care bill, a big part.

Well, maybe, I suppose, if you are trying to kill the bill, you would want to kill the CLASS Act. But this is vi- tally important for our country. It is really the next logical step after the Americans with Disabilities Act. It is going to provide for so many people in this country that security and that peace of mind of knowing they will not have to go into a nursing home or an institution if they become disabled. And it can happen to any one of us here on the Senate floor, our families, our staff, our loved ones. No one knows what might happen to us either from an accident or a physical ailment. No one knows. But shouldn't we at least have a little bit of this health care security that provides that kind of voluntary program? No one is forced into anything. I guess that is what perplexes me more than anything else—why my Republican friends want to prevent something like a voluntary program—a voluntary program—from going into existence that would do this, that is fiscally sound for 75 years. I just do not get it.

So I hope we will support the Whitehouse amendment and make sure this fund is totally solvent. I think he is on the right track, that if there are savings, to put the money back in there, so maybe that $75 a day could be maybe $90 or something like that, to help people.

I see. Mr. President, we now have a statement from the AARP about the CLASS program. Here is what they said. They said:

Decades of talking to our members tell us that older Americans want to live in their homes as they age. That’s why AARP strong- ly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individ- uals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

Mr. President, I ask unanimous con- sent to have that statement from the AARP printed in the RECORD.

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

AARP STATEMENT ON THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS PROGRAM

WASHINGTON.—AARP Executive Vice Presi- dent Nancy LeaMond released this statement today in support of the Community Living Assistance Services and Supports (CLASS) program:

“Decades of talking to our members tell us that older Americans want to live in their homes as they age. That’s why AARP strongly supports the Community Living Assistance Services and Supports (CLASS) program, which recognizes that older individ- uals and people with disabilities should have the right to live independently in their own homes and communities, and to receive the help they need without having to spend down to poverty.

“With nearly 40 million members age 50-plus, AARP has fought to strengthen long- term services and supports. We thank the House and Senate for including the CLASS program in their health care reform bills. The voluntary CLASS insurance program will promote independence, choice, dignity and personal responsibility. It is self-funded and fiscally responsible. AARP believes the CLASS program has been strengthened throughout the legislative process. We look forward to working with the Administration to enact this critical program. America’s seniors and persons with disabilities deserve nothing less.”

M. HARKIN. Mr. President, I am going to add a child in personal terms. The personal terms I have told this story before, and I am going to tell it again because I think it indicates why we need a program such as this.

I have a nephew, Kelly; my sister's brother. He got injured in the military. He actually started small business and employed some people. He has lived a full life. He is now a man of about 50. He has had a great life. Even with that disability, he has been able to get around and do things. He is a taxpayer. He has paid taxes. He has employers. Every night when he goes home, he has to have a nurse come in the home and get him ready for bed and for him to do his exercises and things such as that. Then, in the morn- ing, he has to have another nurse to get him out of bed and take care of his needs, get him ready to go. Actually, Kelly gets his own meals and stuff. Then he goes off to work and comes back. This happens every day.

How was he able to afford to do that? He did not have any money. He did not have any insurance. How was he able to afford to do that? He got injured in the mil- itary. He got injured in the mil- itary. So for all these years, the Veterans' Administration has been paying for this. It has been wonderful. It has kept him out of an institution, kept him out of a nursing home, and it has allowed him to live by himself, to go to school, to go to work, to be with his family, to be with his friends.

I have often thought, this is wonder- ful, but why should that just be for people who are in the military? What about so many other people who get injured like my nephew Kelly who are not in the military, maybe even in- jured before they could go into the military? He was only 19 when it hap- pened to him. So for all these years, I have thought we should have some sys- tem in this country that would allow people like my nephew—who were not in the military but who, through an unfortunate accident, became disabled—so that they could have the same kind of life, where they could live in their own homes in their own commu- nities with their own families, have their own friends. That is why this is so important. This is perhaps one of the most important things we have done since the passage of the Ameri- cans with Disabilities Act to make sure people with disabilities have a full, enjoy- able, productive, quality life.

I hope Senators will decisively defeat the amendment that wants to strike this. Say yes. Say yes to so many people with disabilities and young people today and working people today. Say yes that we are going to have a system whereby you will have the peace of mind knowing you want to contribute the money, you will be able to do so. Say no to the amendment that would strike that, and say yes to the Whitehouse amendment that actu- ally supports the CLASS Act, makes people public with disabilities and young people benefit from it and are reinvested in that program.

I thank the President and I yield the floor.
The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Before we go to our next speaker, I wish to ask if I could request that the next half hour be equally divided; is that OK?

The PRESIDING OFFICER. The Republican deputy leader.

Mr. KYL. I had hoped to take the next half hour, but if we could do 40 minutes, equally divided, I could take 20.

Mr. DODD. Forty minutes, equally divided.

Mr. KYL. Would I be able to take the first 20 minutes then?

Mr. DODD. Yes. That would be under the same order as we had before, I would ask the Chair.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona is recognized.

Mr. KYL. Mr. President, we are discussing the Hatch motion to preserve Medicare Advantage. I wish to give a little bit of background about the Medicare Advantage Program. It was established with the goal of ensuring that Medicare beneficiaries all across the country would actually have Medicare choices. Under the program, private health plans receive government payments in order to serve Medicare beneficiaries. In addition to offering comparable coverage to Part A, which is for hospital payments, and Part B, which is for physicians and other services, Medicare Advantage plans can also offer Part D coverage, prescription drug benefits.

The central goal of the Medicare Advantage provisions was to ensure that beneficiaries across the Nation, not just those in populous areas, would have access to health plan options. Under the law, Medicare Advantage plans must provide all physician and hospital Medicare benefits.

Here is the key: I hope my colleagues will think about this for a moment because this has been a little bit perhaps distorted in the conversation we have had. If a plan’s costs to provide all the Medicare benefits is less than the government payment, then by law, the government payment, otherwise called the risk adjustment, must be used to provide additional benefits to the beneficiary or to reduce premiums.

It seems to me that is what this whole reform was about in the first instance; to try to ensure quality care and reduce the cost of insurance to beneficiaries.

But what are these extra benefits? We have heard them discussed. They include, first of all, lower cost sharing, including out-of-pocket limits on beneficiary cost sharing, as well as specific health benefits such as vision, dental care, hearing services, routine physical, cancer screenings, and so on. Plans can also offer management services, which can be particularly important for seniors with chronic illnesses, and that is a protection, by the way, that does not exist in regular fee-for-service Medicare.

Today, every beneficiary has health plan choices. Since 2003, the number of Medicare beneficiaries enrolled in private plans has nearly doubled from 5.3 million to 10.2 million in the year 2009, according to the Kaiser Family Foundation. So these are very popular plans and growing in popularity.

Let’s go back in time just a little bit to consider the history, back to 1972, because in past years my colleagues on the other side of the aisle were all for Medicare Advantage. Over the years, Congress has cut Medicare spending by reducing payments to private Medicare plans. One problem was, severe payment reductions resulted in the elimination of plan options. For example, in 1997, the Balanced Budget Act reduced plan payments by $74.5 billion over 10 years. What happened? Well, about three-quarters of a million beneficiaries, from 1999 to 2003, had to change plans or else lose their health plan altogether. This included not only beneficiaries in more rural areas of the country but also areas such as Long Island, NY.

Well, Congress heard from these seniors loudly and clearly. They were angry about losing their coverage. Many remember that the Medicare Modernization Act was a landmark achievement which provided seniors with prescription drug coverage, but it was necessary for another reason as well and that was to respond to the call of the seniors who wanted their private options back.

So, in 2003, the Medicare Modernization Act expanded plan options to include regional PPOs and restore plan payments. It was a deliberate, bipartisan decision to increase the plan’s payments so they could enter rural areas of the country and even some of the urban areas—as I mentioned, Long Island. If my colleagues don’t remember, let me remind them.

Former Senator Clinton from New York, for example, said that these Medicare+Choice plans—that is now what we call the Medicare Advantage plans, and I am quoting: . . . are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. While we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today.

The current senior Senator from Massachusetts said at the time, and I quote: I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice program for seniors. This should be among our highest priorities in this new Medicare debate.

It was, and we did. So this is not something bad that we provided this money to these plans. We provided it so the plans could provide the benefits to seniors, particularly in areas where otherwise they wouldn’t have those choices.

So why has this all of a sudden become unpopular with our friends on the other side of the aisle? Well, obviously, first and foremost, they need trillions of dollars to fund their bill, so they look around for where they can get some money and decide: Well, we can get $120 billion from here; this is one way we can help pay for the new entitlements under their plan, for them.

The other 25 percent is returned to the U.S. Government and the other 75 percent, by law, must go to their beneficiaries, either in the form of lower premiums or additional benefits. So these aren’t overpayments to the plans, as has been represented. As I said, 75 percent of the additional payments must be used to provide seniors with extra benefits, which could in turn be providing some basic chronic care management, and so on. The other 25 percent is returned to the government, so there is no overpayment.

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Some on the other side argue that they are protecting guaranteed benefits. Well, this is semantics. Nobody is going after the benefits Medicare has traditionally supplied. What we are pointing out and what this amendment would prevent from happening is, the funding under Medicare Advantage would not be cut, and there is no question—nobody can deny—that those benefits would be cut. In fact, according to the CBO, by the year 2019, they will have been cut by 64 percent, a huge—and almost $300 billion in actuarial insurance companies. As I said, according to the Congressional Budget Office, the legislation would cut benefits from $135 a month actuarial value to $49 actuarial
value. That is a real cut. It may not sound like much to some people, but to our seniors, it is a huge hit. They are asking what happened to this promise to let them keep what they have. There is an interesting memo by Jon Family Health Board, to write for the Heritage Foundation on the Medicare Advantage cuts, and here is what they say:

Reform should mean more patient choice and health plan accountability. But these current proposals go in the wrong direction--a system of less choice, less accountability, and eventually lower-quality health care.

That is what the Hatch motion is attempting to prevent, to preserve these benefits for seniors. I have gotten tons of calls, about 500 calls just in the last several days, opposing cuts to Medicare Advantage. I haven't, by the way, received a single call from a senior citizen asking us to make these cuts. I have been reading from these letters. I have read about a dozen of these letters. Let me read a few from constituents who tell us the real effect these cuts would have on them. In my State, we have about 329,000 seniors who are enrolled in Medicare Advantage plans.

One constituent from Phoenix says:

For the past month I have heard a lot about proposed Medicare cuts. Finally, after years of being unemployed and being able to afford only high deductible insurance, I am now in Medicare and have a Medicare Advantage plan. Please tell me you are not cutting Medicare Advantage. Have a heart.

Leave Medicare and Medicare Advantage alone.

We are trying.

A constituent from Peoria, AZ, says: I oppose cuts to Medicare Advantage. I have two family members receiving health care under this program. The care has consistently been outstanding due to the efforts of our personal and coordinating patient care between providers and patients. We have a voice in determining type and scope of our care. Please do not cut Medicare Advantage.

Here is a note from a constituent from Apache Junction:

I have heard reports that if passed, the new legislation will compel seniors to sign up with or cut Medicare Advantage. If so, it would nearly double our health care costs with my present health care provider. I do not want any legislation passed that would nearly double my health care costs with or cut Medicare Advantage. If so, it would nearly double our health care costs with or cut Medicare Advantage. If so, I have several friends currently undergoing chemotherapy and they are wondering if their health would be in jeopardy if Medicare Advantage were cut. Are we not worth saving? Clearly, there are many who want to spend our money on their own priorities. God bless you, sir, for advocating on our behalf.

These are real concerns from real people. They don't want us to cut Medicare Advantage.

The final point I wish to make is one of our colleagues was saying: Well, there are bad Medicare Advantage plans and good Medicare Advantage plans. How do we know which ones are good and bad? It turns out the senior Senator from Florida devised a formula which protects a lot of folks in his State, especially in Broward County, Miami Beach, Palm Beach, but doesn't protect very many other folks.

Maybe this is the definition of good versus bad. There are a few that are protected in Colorado, Maryland, Mississippi, Oklahoma, and Texas. In my State of Arizona, with a lot of retirees, very few are exempted from the cuts. This is not going to go over well—too frequent a few in each key areas, and none of the others.

Again, what happened to the promise that everyone gets to keep what they have?

My bottom line in supporting the Hatch amendment is that we should not punish seniors and good Medicare Advantage plans. How do we know which ones are good and bad? It turns out the senior Senator from Florida devised a formula which protects a lot of folks in his State, especially in Broward County, Miami Beach, Palm Beach, but doesn't protect very many other folks.

Maybe this is the definition of good versus bad. There are a few that are protected in Colorado, Maryland, Mississippi, Oklahoma, and Texas. In my State of Arizona, with a lot of retirees, very few are exempted from the cuts. This is not going to go over well—to exempt only a few in each key areas, and none of the others.

Again, what happened to the promise that everyone gets to keep what they have?

My bottom line in supporting the Hatch amendment is that we should not punish seniors and good Medicare Advantage plans.

There are better ways to reform health care. We have talked about those ways. Our senior citizens have paid into the program. They have asked us for this program. Democrats and Republicans have supported it in the past. Now, simply because somehow or other we have to scrape up money for the new entitlements in this legislation, we are going to attack the very program all of us have supported in the past.

It is unfair, it is not right, and we need to defeat those cuts in Medicare, and that is why the Hatch motion to preserve Medicare Advantage should be supported by all of us. The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, before the Senate from Arizona leaves, on the point he made and the efforts by the members of the other party to strike Medicare Advantage, I have a letter that was sent to members of the Medicare conference on September 30, 2003, with more Democratic signers who are still in the Senate than Republican signers who were in the Senate, which I believe. The preserved Medicare Advantage was so very important and why it needed to have more money put into the year 2003.

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For instance, I will read from the letter: For nearly 5 million Medicare beneficiaries across America, Medicare Plus Choice—That is what it was called before Medicare Advantage—

is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they offer excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the “Medicare Plus Choice Equity and Access Act.”

Wish supported by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options.

Another constituent from Iowa is recognized.

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care decline. Each year, health plans deprived of essential funding have been forced to eliminate benefits, increase seniors’ out-of-pocket costs, or even withdraw completely from certain markets.

We strongly support additional Medicare+Choice funding for two very important reasons: (1) to protect the health care of the Medicare Advantage beneficiaries who are currently enrolled in private sector health plans; and (2) to strengthen the foundation for future health plan choices.

We believe that the Medicare+Choice funding provisions in H.R. 1 are critically important to preserving choice and quality for America’s seniors. We urge you to include these provisions in the final bill reported out of the Medicare conference committee.

Sincerely,
Rick Santorum, John F. Kerry, Arlen Specter, Jon Corzine, Gordon Smith, Jim Bunning, Dianne Feinstein, Joseph I. Lieberman, Patty Murray, Chuck Schumer, Frank R. Lautenberg, Hillary Rodham Clinton, Ron Wyden, Mark Dayton, Norm Coleman, Mary L. Landrieu, Mary Cantwell, Christopher J. Dodd.

Mr. GRASSLEY. Mr. President, does the Senator from Wyoming want the remainder of our 20 minutes?

Mr. BARRASSO. Yes.

Mr. BARRASSO. Yes.

Mr. BARRASSO. Mr. President, to correct something I heard on the floor today, when the senior Senator from Connecticut had some concerns about this, he said how private health plans deny claims. He said Medicare doesn’t deny claims.

In the United States of America, the No. 1 denier of claims for health care is Medicare. The study that is out from a full year, from March 2007 to March 2008, Medicare rejected 475,000 claims of its 6.9 million claims filed, at the rate of 6.85 percent. When you compare that to private insurance companies, the industry average for the claims that are rejected is about 4.05 percent.

So how, by number, 10 times more than the largest private insurance company. A lot of these claims—I have followed this closely because I have been the medical director of something called the Wyoming Health Fairs, where people can get their blood tested at a low cost. It is a preventive or prevention-designed program. Yet Medicare refuses to pay for prevention. It refuses to pay for these blood tests because they are preventive as opposed to diagnosing a specific problem in a specific patient with a specific symptom.

What do our seniors in America do? They turn to a program called Medicare Advantage because it gives them the advantage of choosing this program. It is one of the choices they have under Medicare. At this point, 11 million Americans have chosen to participate in Medicare Advantage and receive their health care through Medicare Advantage. We are talking about seniors who are currently enrolled on Medicare for their health care.

The number of people signing up for Medicare Advantage has continued to increase, and now there are 11 million people—or one out of every four seniors—on Medicare in this country. They know who they are and they like the program. The reason they like the program is because they get additional services beyond what some—some health plans on Medicare Advantage does. Medicare Program receives, such as dental care, hearing care, eye care, preventive care, and coordinated care.

We hear a lot about the failings of the health care system, and there are many things that are wrong with it, but the biggest problem is that care is not coordinated. People go from specialist to specialist. We need coordinated care. Medicare Advantage does a much better job at coordinating care than traditional Medicare.

It is baffling to me that the plan in front of us in the Senate today is trying to eliminate Medicare Advantage to the tune of over $100 billion. When one looks at the cuts that are in this plan—it is $464 billion in Medicare cuts, $135 billion for hospitals, $42 billion for home health agencies, $15 billion for nursing homes, and $8 billion for hospice providers. But it is $120 billion for Medicare Advantage—the program that helps more seniors to get the care they want to sign up for, because it is an advantage to them to have their health care through a program which focuses on preventive care, coordinated care, and helps them stay healthy and live longer. Yet this Senate and this bill in the Senate floor is trying to completely gut that program and deny our seniors who rely upon it from receiving the care they have earned.

I yield the floor.

Mr. FEINGOLD. Mr. President, I rise in strong support of the Community Living Assistance Services and Supports Act, or CLASS Act, which was introduced by the late Senator Ted Kennedy. The CLASS Act would create an optional insurance program to help pay for home care and other assistance for adults who become disabled. Those choosing to participate would pay premiums based on their insurance trust, and after 5 years, could access a cash benefit if they became disabled and need assistance.

Over 10 million Americans are currently in need of long-term care, and that number is expected to rise to 15 million in the next 10 years. These individuals struggle to remain independent with limited assistance, and many turn to Medicaid as an insurer of last resort. In order to qualify, however, people need to go through a stringent process and have limited income, assets, and commit to unemployment to remain eligible. Mr. President, this is totally inefficient. Instead of ensuring that an individual can remain an independent and functional member of society, the current policy requires that to receive assistance, a person basically becomes a ward of the State. Medicaid pays for half of long-term care costs and increased expenditures now expected to add $44 billion each year to Medicaid over the next decade. Not only is this unsustainable it is nonsensical.

This is as much about protecting people’s dignity as it is about fiscal responsibility. Too many individuals have fallen on hard times, becoming disabled from an accident or illness, with no safety net to help them stay independent. Ensuring that these people have an alternative to Medicaid, so that they can remain active and independent, will reduce the Federal deficit by $73.4 billion over 10 years and save Medicaid $1.6 billion in the first 4 years benefits are available. Medicaid savings will continue to grow over time as more beneficiaries utilize CLASS Act benefits instead of Medicaid.

And thanks to amendments accepted in the Senate Health, Education, Labor, and Pensions Committee, the bill language is stronger than ever. Senator Landrieu, Maria Cantwell, Christopher J. Dodd, Frank R. Lautenberg, Hillary Rodham Clinton, Ron Wyden, Chuck Schumer, Frank R. Lautenberg, Hillary Rodham Clinton, Ron Wyden, Mark Dayton, Norm Coleman, Mary L. Landrieu, Mary Cantwell, Christopher J. Dodd. Sincerely,

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to speak to some of the arguments we have heard.

There is always the question of the substance of an argument. There is also the question of the credibility of an argument. I think as people watch this debate and discuss the credibility of the concern expressed by our friends on the other side of the aisle about the deficit impact of the CLASS Act, it is worth considering a few facts just to evaluate that.

First is that the CLASS Act is required to be actuarially self-sustaining. People pay into it and, from those funds, under the insurance principle, funds come back out. It is required to be self-sustaining that way.

Second, it is voluntary. Nobody has to contribute. If you want to contribute, then you can become eligible for the benefit once you have vested. But nobody is forced into this; it is entirely voluntary. The CBO, on which we rely in a nonpartisan fashion, has said for 75 years that.

Finally, because we think—at least on this side—this matters. It will help the disabled and elderly at that critical point of decision, when their ability to stay home, their ability to stay independent, their ability to stay at work depends on just a little bit of help to accommodate their age or disability, it is then that this will make a difference. What a difference it will make in human lives.

I know the Senator from Connecticut wishes to use an example. I will yield to him on his signal. We have seen this before. We saw this not long ago on the public option, which would compete with insurers head to head on a fair and level playing field. It was completely voluntary, and it had to be actuarially self-sustaining. It had to meet the solvency laws of the State in which it operated. In both cases, our colleagues on the other side have rushed to the floor to talk about deficits when it helps somebody. But a patent, actual living, breathing, deficit-enhancing subsidy that is on the books today is not the CLASS Act.

I said I would yield to the distinguished Senator from Pennsylvania when he arrived, and he has arrived. Without further ado, I yield the floor. Mr. CASEY. Mr. President, I thank my colleague from Rhode Island, Senator WHITEHOUSE, who has been among the more forthright and capable advocates of what we are talking about today. In particular, we need to recognize the role that the CBO, on which we rely, play in this debate and discuss the credibility of the argument that counts.

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to. It is expected to average about $75 a day or more in the case of an individual. That is what we are talking about here.

We are not talking about, in this case, a government entitlement program, but rather a passionately supportive of the Children’s Health Insurance Program or Medicaid as I am. I believe there are programs that are funded by the government, run by the government, that work very well. But in this case, we are not talking about that kind of a program. We are talking about a program that does not confer rights or an obligation on government funding, nor does it affect the receipt or eligibility for other benefits. The program stands on its own financial feet because people are paying premiums out of their own pocket for 5 years to save for that day when they have a need because they have some kind of disability. And it is solvent—voluntary. It is a program that people sign up for voluntarily. It is a voluntary program.

When you line up all of the reasons to support this program that Senator Dodd, as the chairman of our committee, the Health, Education, Labor, and Pensions, this summer when we were debating this bill—he carried the ball for Senator Kennedy in the chairmanship of our committee and in our hearings and also for this program. I am grateful for his leadership and also grateful for Senator Harkin’s leadership to support this voluntary program. I am also grateful that Senator Whitehouse has lent his voice and his expertise and his focus on getting this program as part of our health care reform bill.

It makes a lot of sense. It is solvent, and it will help those who have a disability who want to work, who want to provide independence, self-respect, and dignity in our society.

Second, it keeps the caregivers and the loved ones from carrying that burden all by themselves and not having to sacrifice their jobs and their time and their heartache to share their children’s journey with their parents and dividing a family in that way.

This is at the heart of what our country should be about. It is not who wins—the Republicans or the Democrats. It is not a government program. It is self-funded. It is voluntary. There is no taxpayer money involved. So what other reason could there be but politics to keep people from coming together on this issue?

I urge my colleagues—all on this side and my Republican colleagues on the other side—to think about those families who are facing this plight. They are Republicans, they are Independents, and they are Democratic families as well. This is an American program for some veterans and others who have sacrificed.

I think the only thing we can do, the only right thing we can do, if this is going to be a reflection of the character of this Nation, is to support the CLASS Act.

I thank Senator Dodd once again. I am proud to be standing at the desk of Senator Edward Kennedy who believed deeply in this issue, who started a long time ago and wanted to see it fulfilled.

I yield the floor.

The PRESIDING OFFICER. The time of the majority has expired.

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

The PRESIDING OFFICER. The clerk will call the roll.

Mr. DODD. 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. DODD. Mr. President, I am about to, on behalf of the majority leader, propound a unanimous consent request.

Mr. President, I ask unanimous consent that at 3:30 p.m. today, the Senate proceed to vote in relation to the following amendments and motion to commit, as listed in this agreement, with no other amendments, motions to commit, or any other motion except a motion to reconsider and table upon the conclusion of any vote, being in order during the pending of this agreement; further, that prior to the second and succeeding votes, there be 2 minutes of debate, with all time equally divided and controlled in the usual form; that any amendment or motion covered under this agreement be subject to an affirmative 60-vote threshold, and that if any achieve that threshold, then it be agreed to and the motion to reconsider be considered made and laid upon the table; that if it does not achieve that 60-vote threshold, then it be withdrawn; that after the first vote in this sequence, the succeeding votes be 10 minutes in duration.

A Senator Whitehouse amendment re: Social Security fiscal responsibility; the Republican leader’s designee motion to reconsider; the Republican leader’s designee motion to reconsider; Senator Stabenow’s side-by-side amendment re: Medicare Advantage; and Senator Hatch’s motion to commit re: Medicare Advantage.

Further, that once this agreement is entered, the Republican leader’s designee be recognized to call up the fiscal responsibility amendment; and that once it has been reported by number, Senator Stabenow be recognized to call up the Medicare Advantage side-by-side amendment; and the disposition of the amendments and the motion in this agreement, the next two matters for consideration will be a Senator Lincoln amendment regarding insurance executive compensation, and Republican leader’s motion to commit regarding home health agencies; that for the remainder of today’s session, no further amendments or motions to commit be in order, with the time until then being equally divided between the leaders or their designees, with Members permitted to speak up to 10 minutes each.

The PRESIDING OFFICER. Is there objection?

Mr. McConnell. Mr. President, reserving the right to object, and I will not be objecting, I see the assistant majority leader on the Senate floor. I think it would be helpful, as soon as the majority leader or someone on that side can do so, to indicate at what point during the day tomorrow and at what point during the day on Sunday we might be having additional votes. It might be helpful to our colleagues on both sides of the aisle in terms of planning for the weekend.

The PRESIDING OFFICER. The majority leader.

Mr. Reid. Mr. President, I would say through the Chair to my distinguished colleague, the senior Senator from Kentucky, that we are going to come in at 10 in the morning. At this time, it appears Senator Lincoln will offer an amendment, and I would hope we will be ready at that time to have whatever the minority wants to do in regard to that amendment. Then we are going to have an amendment offered by the Republicans. I would hope that we can dispose of those two amendments tomorrow in the early afternoon—maybe 2:30 or 3 o’clock start voting on them.

Mr. McConnell. So am I correct in assuming that the votes are most likely going to be in the afternoon tomorrow, or both morning and afternoon?

Mr. Reid. In the afternoon, I think we will need some debate in the morning.
Then Sunday morning, at the request of the Republican leader, we are not going to come in until noon, or thereabouts.

Mr. McCONNELL. I think we are going to need some debate time. Oh, we will have that in the afternoon.

Then, on Sunday afternoon, we would not go in until noon on Sunday, and the votes will be—

Mr. REID. There is an event in Washington that a number of Senators are obligated to go to that is in the evening, that everybody out of here by 6, 6:30 that night, at the latest.

I would also say, Mr. President, through the Chair to my friend, that we Democrats are going to have a caucus—tentatively scheduled to have one Sunday afternoon.

The PRESIDING OFFICER. Is there objection to the request?

Hearing no objection, it is so ordered.

The Senator from South Dakota.

AMENDMENT NO. 2901 TO AMENDMENT NO. 2786

Mr. THUNE. Mr. President, I would like to call up amendment No. 2901 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from South Dakota [Mr. THUNE] proposes an amendment numbered 2901 to amendment No. 2786.

The amendment is as follows:

(Purpose: To eliminate new entitlement programs and limit the government control over the health care of American families.) Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

Mr. THUNE. Mr. President, I want to speak to the amendment that we just filed at the desk. This amendment is very straightforward and very simple. It says what a number of my colleagues on the other side have asked us to do, and that is to strike the CLASS Act from the underlying health care reform bill that is being debated on the floor of the Senate right now.

I want to read to you some excerpts from a letter that seven Democratic Senators, including the chairman of the Senate Budget Committee, Senator CONRAD, put together asking that this CLASS Act not be included as part of this legislation.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from which I will be quoting.

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


Hon. HARRY REID, Majority Leader, The Capitol, Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate health care bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But analysis results from the fact that the initial payout of benefits wouldn’t begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit problem. Senator SCHUMER and Senator BAYH have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency.

We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenue. This case essentially reverses the savings from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority. We move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The Act would increase the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD,
JOE LIEBERMAN,
MARY L. LANDRIEU,
EVAN BAYH,
BLANCHE L. LINCOLN,
E. BENJAMIN NELSON,
MARK R. WARNER.
U.S. Senators.

Mr. THUNE. Mr. President, the letter said:

We urge you not to include these provisions in the Senate’s merged bill, nor to use the savings as an offset for other health items in the merger. While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

The letter goes on to say:

[N]early all the savings result from the fact that the payout of benefits wouldn’t begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first 10 years.

They go on to say in this letter, Mr. President:

We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenue. This is especially the case if savings from the first decade of the program are spent on other priorities.

That, Mr. President, is a letter that was signed by the chairman of the Senate Budget Committee, Senator CONRAD of North Dakota, Senator LIEBERMAN, Senator LANDRIEU, Senator LINCOLN, Senator WARNER, Senator NELSON, and Senator BAYH. Seven Democratic Senators have gone on the record saying the CLASS Act shouldn’t be included in this legislation because it is not fiscally responsible.

The fact is, the chairman of the Senate Budget Committee, Senator CONRAD, has described this as a Ponzi scheme of the first order—something that they said was like the Enron Madoff scheme and was a fraud.

Now, I have heard my colleagues get up and talk about how solvent this is and what a great program this is. Well, there are programs out there that are available for people to buy long-term care insurance. The problem with this one is that it takes all the money that comes in in the early years and spends it on other government programs—in this case health care reform—but who knows what other government programs are going to be cut. It will use the revenues that come in from this plan that supposedly a lot of people are going to sign up for, and CBO says it is going to be fewer than 4 percent that will sign up.

In fact, no senior today is going to benefit from it because you have to work for 5 years. If you are a senior who is retired, you will not see any benefit. This doesn’t impact seniors, contrary to the assertions of some of my colleagues on the other side. It will impact future generations of Americans who are going to be stuck with the deficits and the debt that gets piled on them because of the outyears when their liability is increased because of people starting getting paid out, from having paid in, and there is no money there. It is the classic definition of a Ponzi scheme: The money comes in today, it gets spent on other things, and then someday, when the liability comes in and people start saying: I paid into this program, and I should get some benefit, there will be no money there. So we will borrow for it or tax for it or something else.

We say, well, it is actuarially solven—

Congressional Record — Senate S12389

December 4, 2009
The Congressional Budget Office agreed, saying:

The CLASS program included in the bill would generate net receipts for the program in the initial years when total premiums would exceed benefit payments. But it would eventually lead to net outlays when benefits exceed premiums. In the decade following 2029, the CLASS program would begin to increase budget deficits.

This particular quote could come as a bit of a surprise because this comes not from the CBO or the CMS actuary, but it comes from the Washington Post. The Washington Post called the CLASS Act a “gimmick” and not “saving that health care is fully paid for.” The Post goes on to say:

[The money that flows in during the 10-year budget window will flow back out again. These are not “savings” that can honestly be counted on the balance sheet of reform.]

Even the Washington Post recognizes this for what it is. It is a sham. This is a budget gimmick, Mr. President, that is designed to obscure the cost of this program and to cause confusion among the American people.]

Mr. President, this is not good policy. Certainly, if you look at programs we already have on the books, Medicare is destined to be bankrupt in the year 2017. We have big problems down the road—unfunded liabilities in Social Security. This would create a huge new liability down the road that would be unfunded because all the money that comes in during the early years is going to be spent. This is more of the same old business as usual in Washington, DC, that the American people are fed up with. We can make people happy today by saying we are creating roost. Who will pay the bill for that? Future generations of Americans.

Mr. President, the CLASS Act is designed to obscure the cost of this program and to cause confusion among the American people.]

Mr. President, I reserve the remainder of my time.

Mr. KYL. Mr. President, the Community Living Assistance and Services and Support Act, known as the CLASS act, is a new, government-run, government-funded program for long-term care, intended to compete with long-term care plans provided by private insurers.

One of the oft-repeated arguments we have heard in favor of the CLASS act is that it would reduce budget deficits between 2010–2019. First, when has a government program ever reduced budget deficits? Second, the Congressional Budget Office tells us that this program will actually add to future Federal budget deficits. The CBO writes: “The program would add to future federal budget deficits in large and growing fashion.”

Why would you do that? The program offers returns that payments made into the system cannot cover—just like a Ponzi scheme, as Senator CONRAD said. Participants would have to pay into the system for five years but collecting benefits. Under the Senate proposal, only active workers could enroll in the program. So this would not be a program that would not benefit seniors or the currently disabled. So, if a worker began making payments in 2011, he or she could not collect benefits until 2016. So, for a time, the program would generate surplus receipts for the government while Americans are paying in and not collecting benefits. But eventually, we will reach a point when payments made into this program cannot sustain promised benefits.

As the CBO tells us, the program would lead to net outlays when benefits exceed premiums. (By the third decade of program operation—2000–2009 CBO assumes that CLASS begins to generate net increases in Federal outlays. The net increase in Federal outlays is estimated to be “on the order of tens of billions of dollars for each (succeeding) ten-year period.”)

Second, the Congressional Budget Office notes that net Federal outlays which will begin to occur after 2029 results despite the requirement that premiums be set to ensure the program’s solvency over 75 years. The solvency requirement counts interest income paid to the program’s trust fund as available to pay future benefits. However, CBO notes that those interest payments are an intra-governmental transfer within the Federal budget. Thus, CBO notes that from a budget scorekeeping perspective, the CLASS program’s interest payments involun-
tarily add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiuns would be set to ensure solvency of the program.

The administration’s chief health actuary said the CLASS Act would result in “a net federal cost in the longer term.”

Bottom line, this program is not sustainable outside the 10-year window. That is why the Washington Post called it, “a gimmick . . . designed to pretend that healthcare is fully paid for.”

The Post goes on:

Money that flows in during the 10-year budget window will flow back out again. These are not “savings” that can honestly be counted on the balance sheet of reform.

Mr. DODD. Mr. President, how much time remains?

Mr. FRANKEN. I thank the Senator. I need 3 minutes.

Mr. DODD. Take 4.

Mr. FRANKEN. I will use it. The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Mr. President, I rise today to ask unanimous consent to be added as a cosponsor to the amendment of Senator COBURN, amendment No. 2789, to require all Members of Congress to enroll in the public option. I am pleased to cosponsor this amendment. It would strike the CLASS Act, because I strongly support the public option and I will have no qualms at all enrolling in this plan.

There is a lot of misinformation about the public option, so I want to be clear about why we need a public option and why I would be proud to enroll in a public health insurance plan.

We need a public option because health insurance premiums for Minnesota residents have risen 90 percent since 2000 and because 444,000 Minnesotans went without health insurance in 2008. We need a public option because while millions of Americans struggle to pay for health care, insurance executives continue to make bloated, obscene salaries. From 2000 to 2007, American families saw their premiums almost double. During that same time, we saw more than 6 million more Americans become uninsured. During that same period, insurance companies’ profits rose 428 percent—428 percent in 8 years. They are making outrageous profits by gouging American families. That is why we need a public option.

The public option will offer affordable premiums and a comprehensive benefits package for Americans struggling with their health care costs. It is good because Americans need to be healthy. The public option will foster competition among private health insurance companies and lower long-term costs for Minnesotans and for families all across the country. There is no cost for the public option to the Treasury. In fact, CBO estimates it saves $3 billion. It is a win-win situation.
It is important to remember that a public option doesn’t mean private health insurance goes away. In fact, after health reform, 188 million Americans will have coverage through a private insurer. Only 2 percent of the overall insured population is projected to enroll in the public option. It is a little curious that two of the sponsors, at least, Senator Coburn and Senator Vitter and some others, are so gung-ho about going on it, as I am, correct?

Mr. FRANKEN. Absolutely. I talked to my wife Franni. We have been married 34 years now. I talked to her a couple of weeks ago. I said if this passes, we should do the public option. She said, absolutely. Yes. I am perfectly serious about this.

The PRESIDING OFFICER. The Senator from Michigan has consumed 4 minutes allotted by the clerk.

Mr. BROWN. Will the Senator from Minnesota yield?

Mr. GRASSLEY. I yield 5 minutes to the Senator from Utah, Mr. Hatch.

The PRESIDING OFFICER. Without objection, the request of the Senator from Minnesota to be added as a co-sponsor of the Coburn amendment is ordered.

The Senator from Utah is recognized.

Mr. HATCH. Mr. President, we are talking right now about a program that was well thought out, that was meant to help the poor and minorities. It was a bipartisan effort by Democrats and Republicans, and has worked amazingly well and is available to all recipients of Medicare.

Medicare Advantage came about in a bipartisan way to solve real problems. We were not getting health care to rural America. We were not getting health care, in many respects, to some of the poorer, some of the minority folks in our country.

I want to read a special letter here.

Let me read this letter. I know it may have been read before, but I am going to read it again. It is dated September 30, 2003. “Dear Medicare Conference.” I happened to be a member of that conference. I was one of those in there who led the fight for Medicare Advantage.

We are writing to ask you, as a member of the Medicare conference committee, to ensure the final Medicare bill includes a meaningful increase in Medicare+Choice—

That is the predecessor to Medicaid Advantage.

funding in fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice (the predecessor program that provides an effective means to ensure high-quality, comprehensive, affordable health coverage) and disabled Americans have voluntarily chosen to receive Medicare Advantage from Medicare HMOs and other private plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the “Medicare+Choice Equity and Access Act.”

That became Medicare Advantage. Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice programs.

It goes on to make a compelling case for what came from that conference as Medicare Advantage, and that was utterly pleasing to everybody who signed this letter.

By the way, let me just mention the Democrats who signed this letter, who wanted Medicare Advantage: John Kerry, Arlen Specter, Dianne Feinstein, Joe Lieberman, Patty Murray, Charles Schumer, Frank Lautenberg, Hillary Clinton, Ron Wyden, Mark Dayton, Mary Landrieu, Maria Cantwell, and Christopher Dodd. Fourteen Democrats signed this letter, along with a number of bipartisan Republicans, who believed we really needed to include Medicare Advantage.

Now, to take advantage, our colleagues on the other side want to do away with Medicare Advantage, except in 3 States that are, for the most part, Democratic States, leaving all the other 46 States high and dry.

Let me just say that this letter is in response—it was a letter given to the Medicare modernization conference committee. This conference committee gave them exactly what they wanted for Medicare Advantage. This legislative grant of power gave the signatories the Medicare Advantage Program, which now 11 million senior citizens enjoy today.

Now those on the left want to do away with this important program that benefits seniors and minorities in an amazing set of ways. I am against that effort. I hope our colleagues on the other side will realize what they are doing. It just is not right. Vision care and dental care and so many other approaches that really work for this program will be taken away from these people. They are going to have to spend $175 to $200 a month to get what they got for an average of about $54 a month. These are people who need our help.

Let me change the subject for a minute because I understand my colleague from Oregon was discussing Medicare Advantage and talking about some Medicare Advantage companies living “high off the hog” and inferring that is a rationale for $120 billion in Medicare Advantage cuts. I have two responses to my colleague from Oregon. This is not about Medicare Advantage insurance companies, this is about preserving the choice of coverage for seniors.

The PRESIDING OFFICER. The Senator from Utah has used 5 minutes.

Mr. Hatch. I ask for another 2 minutes.

Mr. DODD. How much time remains for both sides?

The PRESIDING OFFICER. The Senator from Iowa controls 4 minutes 46 seconds; the Senator from Connecticut, 4 minutes 42 seconds.

Mr. DODD. The Senator has 4 minutes.

Mr. HATCH. He also said that under the Reid bill, Medicare Advantage beneficiaries will be able to keep what they have due to the Nelson grandfathering amendment passed by the Senate Finance Committee this fall. But those protections primarily apply to Medicare Advantage beneficiaries in Florida, Oregon, and New York—beneficiaries living in other parts of the country. Rural areas will not be protected.

So let’s be clear when we say Medicare Advantage beneficiaries’ benefits will not be cut. These extra benefits include lower premiums, deductibles, and copayments, dental coverage, and hearing aids, to name only a few.

Bottom line: Most Medicare Advantage beneficiaries may not keep what they have, contrary to the President’s promise to them.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I yield 4 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 4 minutes.

AMENDMENT NO. 2899 TO AMENDMENT NO. 2786
Ms. STABENOW. Mr. President, I have an amendment that will be sent to the desk pursuant to the unanimous consent agreement. I now call up my amendment No. 2899.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Michigan [Ms. Stabenow] proposes an amendment numbered 2899 to amendment No. 2786.

Ms. STABENOW. 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 ensure that there is no reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.) At the appropriate place, insert the following:

SEC. 1. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Ms. STABENOW. Mr. President, this is a very important amendment to
Mr. LE MIÈUX. Mr. President, I have been reviewing the amendment of the Senator from Michigan. This is very important to the people of Florida because it deals with Medicare Advantage. Medicare Advantage is a very important program that just some extra dollars. It is the idea that our folks in Florida can get eye care, dental care, hearing care, diabetic supplies, preventive medicine. Last week I went down to a Medicare Advantage clinic in Miami, the Leone Center. This is a preventive medicine holistic health care. The intention of this amendment is to guarantee the benefits in Medicare Advantage, but I am not sure it is phrased that way. I have been reading the bill. I have been reading Title XVIII of the Social Security Act. I cannot find the phrase “guaranteed benefit.” I ask unanimous consent that the “guaranteed by law” phrase in this amendment offered by my colleague from Michigan be eliminated so that we would ensure that benefits of eye care, dental care, preventive care, diabetic supplies, all the other things that are provided in Medicare Advantage, are actually preserved. No one is objecting to lower costs. No one is objecting to a competitive situation where we have companies providing more services for less cost. We want to make sure the services are still there. I ask unanimous consent to have that phrase “guaranteed by law” be eliminated from the amendment.

The PRESIDING OFFICER. Is there objection?

Ms. STABENOW. Reserving the right to object, I ask that my colleague work with me. We will be happy to talk about how we might address what he is concerned about. Unfortunately, the reality is, the for-profit companies are objecting to competitive bidding. The language my colleague has suggested would include items that have been offered to the in people in for-profit plans. So any kind of other things that have been of great concern. Given that, I would have to object.

The PRESIDING OFFICER. Objection is heard.

The time of the Senator from Florida has expired.

Mr. HARKIN. Mr. President, I yield 3 minutes to the Senator from Ohio.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. I have watched from my office on C-SPAN and been on this floor countless times in the last 3 or 4 days as my friends on the other side continue to do the bidding of the insurance companies. I hear them talk about Medicare Advantage, but it is I was in the House of Representatives 10 years ago when Medicare Advantage began, when the insurance companies said: We can save Medicare 5 percent on all its costs by bringing forward Medicare Advantage. Then we had the Republics put control of everything, that savings of 5 percent, the insurance companies decided, no, we can’t save 5 percent anymore. We need a 13-percent bonus. The chickens have come home to roost for the insurance companies, for good and bad.

I refer to a Dow Jones story entitled “Humana 3rd Quarter Profits Up 65%. See Strong Medicare Advantage Growth.” Let me excerpt from the first few paragraphs.

Humana Inc.'s third-quarter earnings rose 65% amid improved margins at its government (i.e. Medicare Advantage) segment.

The company gave an initial 2010 forecast in which the health insurer projects “substantial” Medicare Advantage membership growth, resulting in about $2 billion to $4 billion—well above analysts' average estimate of $2.63 billion. Humana's forecast takes into account reductions in Medicare Advantage over-payments.

As the Senator from Rhode Island knows and the Presiding Officer and my colleagues who have been strong supporters of Medicare, when we see people who have opposed Medicare, opposed the creation of Medicare 40 years ago and now object to provide more in the bill, I ask unanimous consent to have the Hatch amendment, even though I believe we need to do some things to cause Medicare to be more solvent. I do believe that Medicare Advantage does have some subsidies to insurance companies that are higher than they should be. The fact is, this bill is taking money from a program that is insolvent, Medicare, and using that to support the Hatch amendment, even though I would love to work with my friends on the other side of the aisle to do those that
Mr. HARKIN. I yield 2 minutes to the Senator from Illinois.

Mr. DURBIN. Mr. President, this is a basic choice. Will we continue to subsidize private health insurance companies that are overcharging the Medicare Program by 14 percent? Will we take that money out of Medicare to continue the subsidy for profitable private health insurance companies? It is that basic: Is it not? We also have to be honest about those providers overcharging Medicare. Why does it cost twice as much in Miami for the same service that is given to Medicare patients in Rochester, MN? It should not. Somebody is ripping off the system. If we can’t ask those honest questions, then I am afraid we will not put Medicare on sound financial footing. We can do that. But we can’t do that by saying: We have got to continue to subsidize private health insurance companies out of Medicare. That is the Hatch amendment. That is what we should vote against.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. HARKIN. How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 5 minutes.

Mr. HARKIN. I yield 2 minutes to the Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, those of us who have been privileged to hear our friends on the other side debate the public option have seen a relentless insistence on the public option operating on a level playing field with the private insurance industry. I can’t tell the number of times we have heard that. Indeed, even when we designed the public option so that it did operate on a level playing field with the private insurance industry, they still complained. Now we have a situation in which we have private industry operating at a 14-percent advantage and subsidy against Medicare. Suddenly, the other side’s interest in a level playing field has evaporated. Suddenly their interest is in doing what is, once again—in the astonishing coincidence that characterizes debate—in the interest of the insurance industry.

I have heard an argument made from the other side of the aisle that doesn’t happen to coincide with the interests of the insurance industry. It could not be more stark on this point. If it is a public option, they want it to compete on a level playing field. And then they want to fight it. If it is a privately subsidized coverage, getting an advantage against the public system, then they are for it.

I urge consistency and support of the effort to bring some discipline to Medicare Advantage, as the private insurance industry promised. We are doing no more than holding them to their word.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I yield the balance of my time to the Senator from Texas.

Mrs. HUTCHISON. Mr. President, to Senator HARKIN. Mr. President, I understand the Senator from Pennsylvania, Mr. CASEY, filed an amendment designed to spend $2.5 billion to protect Medicare Advantage benefits for Pennsylvanians. What is going on? What is going on here? Why can’t we protect every citizen? That is five States that are “protected” and spending extra billions of dollars. Let’s have an amendment that every State is treated the same. Let’s do that. I tell my colleagues, I intend to introduce an amendment that will do so. That will take away the special exceptions that are taken for special States to have special influence around here.

Mrs. HUTCHISON. Mr. President, to Senator HARKIN. To put it differently, when I hear all of this debate, it is as though everything has to be more government, bigger government, government is better than the private sector. Medicare Advantage is an option. It is not a mandate. It is an option that allows seniors another choice to get eye care, hearing aids. Let’s let seniors have this option. Let’s not cut it away from them. We need more competition, not less.

The PRESIDING OFFICER. The Senator’s time has expired.

Who yields time?

Mr. HARKIN. Mr. President, it was interesting to hear the last speaker say: Don’t take away the option for seniors in Medicare Advantage. Yet they have an amendment to take away the option for people who buy insurance against having a disability so they can stay in their own homes and have support. It is voluntary. It is not mandatory. No one is forcing them to do anything. I say to my friend from Texas. Yet there is an amendment on that side to take away that voluntary program, the CLASS Act, so that people can voluntarily put money into it to protect themselves against a future disability. Let’s kind of keep our arguments a little bit straight.

A lot of people have talked about Medicare Advantage. I will not close the argument on that. I will close on the necessity of keeping the CLASS Act in this bill. I have spoken many times about that. It is a non-partisan issue. It is like when we passed the Americans with Disabilities Act. It was not a partisan issue. This should not be a partisan issue too. We should not let politics get involved. Over 275 groups representing people with disabilities of all ages, from AARP to Paralyzed Veterans of America to the Interfaith Coalition, support the CLASS Act. It was unanimously adopted by the HELP Committee, unanimously adopted by Republicans and Democrats. Senator Gregg offered an amendment to insist that it be actuarially sound over 75 years, and it is actuarially sound over 75 years.

Secretary Sebelius said the administration supports it. President Obama supports it. There is broad-based support for the CLASS Act.

Today we received some letters from people around the country. I don’t have time to read them all but just a couple. Here is one from Arkansas:

My wife has a journalism degree, cerebral palsy and brings money to the state of Arkansas with her stay at home job with occasional travel. If her health worsens she could still earn money for the state under the CLASS Act working from home with the assistance from an attendant, [rather than having to go to a nursing home.]

Here is Virginia:

I don’t currently need the services under the CLASS Act, but having been born with a disability I’ve always been acutely aware of the reality of services down the road . . . it would be a good thing for me, a thirty-year-old working person, [to be able to put some money away] to beg my colleagues, for the sake of people with disabilities, let’s not adopt the amendment of the Republicans to take away the CLASS Act. It was Senator Kennedy’s premier goal.

Mr. GRASSLEY. Mr. President, I take a back seat to no one on issues associated with improving the lives of seniors and the disabled.

As ranking member on the Aging Committee, I oversaw critical hearings in deep and personal in our Nation’s nursing homes. I was the principal author of the Medicare Part D prescription drug bill which is currently providing our seniors and people with disabilities with affordable prescription medications.

On the disability front, one of my proudest achievements is the enactment of legislation I sponsored along with the late Senator Ted Kennedy, the Family Opportunity Act, which extends Medicaid coverage to disabled children.

In large part, through my efforts, the Money Follows the Person Rebalancing
Act, and the option for States to implement a home- and community-based services program were included in the Deficit Reduction Act of 2005.

Along with Senator KERRY, I have introduced the Empowered At Home Act which, among other things, revises the income eligibility level for home- and community-based services for elderly and disabled individuals.

If I thought that the CLASS Act would add to this list of improvements to the lives of seniors or the disabled, I would first in line as a proud co-sponsor of the CLASS Act.

But the CLASS Act does not strengthen the safety net for seniors and the disabled.

The CLASS Act compounds the long-term entitlement spending problems we already have by creating yet another new, unsustainable entitlement program.

The CLASS Act is just simply not viable in its current form.

It is almost certain to attract the people who are most likely to need it—this is known as adverse selection.

That will cause premiums to increase and healthier people to drop out of the program.

It is the classic “insurance death spiral.”

On November 13, the administration’s own Chief Actuary confirmed this. The Chief Actuary issued a dire warning in a report on the CLASS Act in the House bill which is virtually identical to the Senate version.

The Chief Actuary said:

There is a significant risk the program will not be actuarially sound.

The CLASS Act has been characterized by the Washington Post editorial page as a “gimmick.”

For the first 10 years, the CLASS Act saves money at the beginning because it collects premiums before benefits start to be paid out.

But sometime afterwards, it starts to lose money.

We all know what happens from there. It will become the taxpayers’ responsibility to rescue the program as it falls.


You want to protect the benefits of a program that you know will fail is irresponsible.

Creating the unsustainable CLASS Act is irresponsible.

Adding the ticking timebomb of yet another unfunded liability to our children and grandchildren through the CLASS Act is irresponsible.

The responsible vote is to strike the CLASS Act from the bill; I urge my colleagues to support this amendment.

Mr. President, I ask unanimous consent to have Blue Water in the RECORD.

First is an article from Fortune magazine on the CLASS Act. Second is a letter signed by seven of my Demo-

crat colleagues objecting to the CLASS Act.

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

(From Fortune Magazine, Sept. 3, 2009)

THE CRAZY MATH OF HEALTH-CARE REFORM

Embedded in the health-care plan moving forward is a truly gravity-defying new device: a costly entitlement program portrayed as a way to show how you can raise billions with a program that can’t even pay for itself? Only by using the crazy math that governs in the world of health-care reform.

The gimmick was hatched on July 15 when the Senate Committee on Health, Education, Labor & Pensions approved a federal insurance plan for long-term care called the Community Living Assistance Services and Supports Act, or CLASS Act.

The plan, which would provide modest benefits to people who can’t perform such simple daily tasks as bathing or feeding themselves, was one of Sen. Ted Kennedy’s last crusades. It quickly became a favorite among Demo-
crats who opposed the leading proposal in the House, H.R. 3200, passed by the Energy & Commerce Commis-
sion.

While no one doubts the bill’s humane in-
tentions, its ardent champions have another motive as well. A budget gimmick allows them to claim that CLASS Act helps pay for health-care reform.

The Democrats are promising a “deficit neutral” plan, which means that according to rules set by the Congressional Budget Office, they need to find about $1 trillion in new taxes and savings over the next ten years. Right now, the House legislation stands around $65 billion short. The CLASS Act looks like a gift: It brings in $58 billion in net tax revenues by 2019, lowering the deficit by an equivalent amount because only minor costs will be booked dur-
ing that period. Under the CBO rules, the CLASS Act technically covers one-quarter of the $250 billion shortfall in funds needed to pay for health-care reform.

The gimmick lies in looking only at the CBO’s ten-year budget window. The extra revenues are an illusion because of the disaster lurking just beyond that horizon.

In fact, none of the $58 billion is available to pay for the House bill. The CLASS Act is a costly disaster waiting to happen because only minor costs will be booked in the first decade of the program are.$12394

The gimmick is like this: The $1 trillion the AAA deems far too short.

But the CLASS Act does not raise billions with a program that can’t even pay its way.

Class. To pay for the House bill, the CLASS Act will create a giant budget shortfall of its own. Unfortu-
ately, gimmickry like this is the kind of thing that has fanned public fears about health-care reform doing more harm than good.

U.S. SENATE,
Washington, DC, October 23, 2009.

HON. HARRY REID,
Majority Leader, The Capitol,
Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee known as the CLASS Act in the merged bill.

We urge you not to include these provi-
sions in the Senate’s merged bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laud-
able—providing a way to pay for long-term care insurance to individuals—the effect of including this legislation in the merged Sen-
ate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over 10 years. But nearly all the savings result from the fact that the initial payout of bene-
fits would not begin until 2016 even though the program begins collecting premiums in 2011.

Besides, the legislation stand-alone would face a long-term deficit point of countervailing benefits.

Some have argued that the program is act-
ually a win. But this is the case because again, the premiums are collected and placed in a trust fund, which begins earning interest, and be-
cause the HHS Secretary is instructed to in-
crease premiums to maintain actuarial sol-
darity.

This is also clear that the real effect of the provisions would be to create a new federal entitlement program with long-term, long-term spending increases that far exceed the reported savings from the first decade of the program are spent on other health reform priorities.
Slowly the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD, JOE LIEBERMAN, MARY LANDRIEU, EVAN BAYH, BLANCHE E. LINCOLN, E. BENJAMIN NELSON, MARK R. WARNER.

U.S. Senators

The PRESIDING OFFICER. The Senator’s time has expired.

All time has expired.

Under the previous order, the question is on agreeing to amendment No. 2901, offered by the Senator from South Dakota, Mr. Bunning.

Mr. HARKIN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted “yea.”

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 359 Leg.]

YEAS—98

Akaka
Baucus
Bayh
Baucus
Bennett
Baucus
Brown
Brown
Brown
Burr
Burr
Cantwell
Cardin
Carper
Chambliss
Collins
Conrad
Corker
Corker
DeMint
Dodd
Dorgan
Durbin
ENNING

NOT VOTING—2

Voinovich
Webb
Whitehouse
Wyden

Bunning
Byrd

The PRESIDING OFFICER. On this vote the yeas are 98, the nays are 0. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is agreed to.

Mrs. HUTCHISON. Mr. President, parliamentary inquiry: Are the next 3 votes 10-minute votes?

The PRESIDING OFFICER. The Senator from Texas is correct. The next 3 votes are 10-minute votes.

Mrs. HUTCHISON. Thank you, Mr. President.

Mr. LAUTENBERG. Mr. President, I move to reconsider the vote.

Mr. INOUYE. I move that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2901

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2901 offered by the Senator from South Dakota, Mr. Bunning.

Mr. THUNE. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There appears to be.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DODD. Mr. President, I urge my colleagues to support the CLASS Act and vote against the Thune amendment that would strike the CLASS Act from the bill.

As you have heard, I hope, this afternoon, this bill is totally voluntary. There are no requirements by employers or employees to be involved. This is a very creative idea using individuals’ money to contribute to their own long-term financial security if they are faced with disabilities.

We have now, with the adoption of the Whitehouse amendment, secured that these funds can never be used for any other purpose than for the CLASS Act. That was the concern most of our colleagues had. If these funds would drift off. As a result of the Gregg amendment in our committee, it has now been determined that these programs will be actuarially sound for 75 years. We have fixed the problem CBO raised with it.

It is a very creative and solid program that can make a huge difference for millions of Americans to avoid going to Medicare, divesting themselves of their assets, and allowing them to lead independent lives with dignity. It is deserving of our support. I urge the approval of this program.

The PRESIDING OFFICER. Who yields the time?

Mr. THUNE. Mr. President, the CLASS Act is the same old Washington, same old smoke and mirrors, same old games. I wish to read what the Congressional Budget Office and the chief actuary for the administration have said.

The program would add to future Federal budget deficits in large and growing fashion.

If we don’t take this out of this legislation, if we allow this to become law, we are locking in future generations to deficits and debt as far as the eye can see. This is, as has been described by the other side, a Ponzi scheme of the highest order. We need to take it out of this bill.

I urge my colleagues to adopt this amendment.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2901 offered by the Senator from South Dakota, Mr. BUNNING.

Mr. THUNE. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There appears to be.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted “yea.”

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 47, as follows:

[Rollcall Vote No. 360 Leg.]

YEAS—51

Alexander
Baucus
Bayh
Baucus
Bennett
Bennett
Brown
Brown
Brown
 Burr
 Burr
 Cantwell
Cardin
Carper
Chambliss
Collins
Conrad
Corker
Corker
DeMint
Dodd
Dorgan
Feinstein
Franken

NAYS—47

Akaka
Baucus
Bayh
Baucus
Bennett
Bennett
Brown
Brown
Brown
 Burr
 Burr
 Cantwell
Cardin
Carper
Chambliss
Collins
Conrad
Corker
Corker
DeMint
Dodd
Dorgan
Feinstein
Franken

NOT VOTING—2

Voinovich
Webb
Whitehouse
Wyden

Bunning
Byrd

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 47. Under the previous order requiring 60 votes for the adoption of amendment No. 2901, the amendment is withdrawn.

Mr. DODD. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.
The PRESIDING OFFICER. There will now be 2 minutes of debate, equally divided, on the Stabenow amendment.

Who yields time?

The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, this amendment is very clear. My amendment states that nothing in this act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Right now, CBO tells us, and we understand from MedPAC that there is $12 billion in overpayments to for-profit insurance companies, which are additional costs that the Medicare recipients pay beyond what is traditional Medicare.

Eighty-five percent of our seniors in Medicare are in traditional Medicare and, right now, we are told that every single Medicare citizen or person with disability in Medicare pays $90 extra; every couple pays $90 extra to pay for the overpayments to private for-profit insurance companies.

As AARP has said, this legislation does not reduce any guaranteed Medicare benefits. We are asking for competitive bidding—for-profit company competitive bidding—to bring down the overpayments. I ask for support for the amendment.

The PRESIDING OFFICER. The Senator from Utah, Mr. HATCH.

Mr. Hatch. Have no doubt, when we did this, 14 Democrats, many of whom are sitting here in the Senate right now, supported this development of Medicare Advantage.

The PRESIDING OFFICER. The Senator’s time has expired.

Mr. Bond. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. Byrd) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. Bunning).

Further, if present and voting, the Senator from Kentucky (Mr. Bunning) would have voted “yea.”

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 97, nays 57, as follows:

[Rollcall Vote No. 362 Leg.]

YEAS—97

Yielding

NAYS—57

The result was announced—yeas 97, nays 57, as follows:

[Rollcall Vote No. 362 Leg.]
Baucus  Gordon  Johnson  Reid

The Senator from Nebraska [Mr. JOHANNS] moves to commit by Mr. HATCH is withdrawn.

The PRESIDING OFFICER. The motion to commit by Mr. HATCH is withdrawn.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, the Senate from Arkansas is to be recognized to offer an amendment.

AMENDMENT NO. 2905 TO AMENDMENT NO. 2786

Mrs. LINCOLN. Mr. President, I call up amendment No. 2905.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

Mr. JOHANNS. I have a motion at the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

MOTION TO COMMIT

The Senator from Nebraska [Mr. JOHANNS] moves to commit H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include cuts in payments to home health agencies totaling negative $2.1 billion.

Mr. JOHANNS. Mr. President, I rise to speak in favor of the motion that was just read. I think this is so very important about a debate on the Senate floor is we begin to talk about what home health programs do. That is especially true in this case because the impact on seniors’ health care is profound. These cuts will reduce the quality of care many Americans are receiving today and reduce the care these Americans deserve.

I have to tell you, out of all these Medicare cuts, one of the largest head-scratching cuts is the one to home health. The Senate bill cuts $22.1 billion for home health care. Home health is about 3.7 percent of the Medicare budget. It is an important program. Yet 9.1 percent of the Medicare cuts in the Senate bill are taken out of home health.

Medicare home health spends less today than it did over a decade ago, while serving a similar number of beneficiaries at less cost per patient. That is the kind of program we should celebrate. Yet this bill has them on the chopping block.

Maybe there is some misunderstanding about what home health provides, so let me clear up the confusion. Home health care agencies care for patients of all ages. They provide a broad range of essential health care in support services, real security in the comfort of a patient’s home. Nine thousand Medicare-approved home health agencies existed in 2007. I am very pleased to report to you that 74 of those are in my home State of Nebraska. Nurses, therapists, home care aides, and others who serve elderly and disabled patients in their own homes drive nearly 5 billion miles a year to provide these much needed services. They care for about 12 million real people annually, with $28 million visits, each one providing that personal touch of care.

The services that are provided in this very essential program include rehabilitation, physical therapy, wound care, pain management, and skilled nursing.

Who is eligible to receive Medicare home health services? We can answer that question by going to CMS. According to CMS, to qualify for Medicare home health benefits, a Medicare beneficiary must meet one of the following requirements: They must be confined to home, they must be under a doctor’s care, they must need skilled nursing on a periodic basis, and they must have a continuing need for occupational therapy. These are truly some of the most vulnerable Americans. Yet in order to finance this new entitlement, this bill takes money out of that much needed program, and it places the cuts on the backs of these Americans, our most vulnerable Americans. Yet these cuts risk leaving them without care.

What kind of conditions do people who utilize home health agencies suffer from? I will turn to my own State to answer that question. In Nebraska, one of our agencies is in rural Cherry County. Cherry County is a very large county in western Nebraska—in fact, larger than some States. Who gets served in Cherry County? A gentleman with class III congestive heart failure. He is awaiting a heart transplant. A gentleman who lost his leg due to complications from diabetes, they get home health care services. These folks are not striving to bilk the system. The payments that allow us to provide this much needed service to them are not excessive payments. These are just average folks who are striving to do their best to recover from their condition and manage the best they can.

Keeping these folks out of the emergency room or the nursing home is a benefit to everybody. I don’t see how anybody could argue that tax dollars. In fact, there are statistics that support that statement. According to the National Association of Home Health Care and Hospice, an average per-visit Medicare charge for home health is $132. Let me compare that charge of $132 to a day at a hospital. That would cost 43 times as much, literally—$5,765 per day.

According to a study of Avalere Health:

Early use of home health services following a hospital stay by patients with at least one chronic disease saved Medicare $1.71 billion in the 2-year period of 2005 to 2006.
Doesn’t it seem like an enormous step backwards when we talk about reform, when really what we are doing is cutting a program that serves people so much in need and yet saves money in the Medicare Program? Home health agencies in Nebraska have been very successful in doing exactly what they want—keeping people at home and out of the hospitals and nursing homes. Of special interest are patients with congestive heart failure. One Nebraska woman turned to home health after facing a big stack of hospital bills for rehab. Since then, she has been able to remain at home safely at a fraction of the cost. This home health agency can see a person for 60 days at a cost of about $2,500. One hospital admission, by comparison, would cost Medicare conservatively $20,000 to treat a patient with chronic heart failure. Again, home health care costs a fraction of hospital care, about 10 times less.

There are many stories from patients who are alive today who love home health care. This bill threatens them. Somewhere in the next hours, I am going to send to every Member of the Senate, all of my colleagues, a State, and a Congressional analysis of what the cuts will do in their States because they need to know the impact. This bill threatens to take that all away. You can’t cut $42 billion and just describe it as excess payments. You can’t cut $2 billion and say: That is just fixing those who are bills. You look at the system. When you cut $2 billion out of a program like home health care, it has real consequences.

Earlier this week, I did a videoconference with Medicare providers in Nebraska. These Nebraska home health providers reported this legislation will cost them $120 million. What does that mean, $120 million? It may not sound like much around here, where we talk about trillion-dollar programs, but $120 million in Nebraska is a big chunk. In home health care, 68 percent of home health agencies in Nebraska will be in the red by 2016, 68 percent. In rural areas, as high as 80 percent will have negative margins. You lose those services in rural areas. They are lost. There is nothing that will step in for those people.

Home health providers already have to watch their bottom line, and they are already making very hard, painful decisions. During this videoconference, a nurse in rural Nebraska explained the reality to me this way: ‘I can give you a human story that just happened yesterday in our agency. We had a referral from a patient that lives 96 miles away. The drive time is three hours. To do the administration takes 1½ to 2 hours. Then you come back to the office and you do at least a couple of paperwork. It would take one person’s entire day to serve one patient. Regrettfully, we had to say no. We just take one person’s entire day to serve one patient. And some patients are even sicker than that.

Ms. KLOBUCHAR. I ask unanimous consent to speak for up to 12 minutes.

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

Ms. KLOBUCHAR. Mr. President, I rise to speak about a true health care reform. The way I look at this in my State, it is a matter of affordability and cost. We have one of the highest percentages of people covered in the country in Minnesota. The issue is, it is becoming too expensive for the people to afford health care. I always try to remember three simple numbers of all the ones we will hear in the next few weeks. Those are the numbers 6, 12, and 24. Ten years ago it cost $6,000 for an average family to pay for health care a year. Now it is $12,000, with a lot of people paying a lot more. Ten years from now, if we don’t do anything, it will be somewhere between $60,000 and $80,000 for something regular people just can’t afford. It is not going in the right direction.

If we don’t act, costs will continue to skyrocket. The country spent $2.4 trillion on health care last year alone. That is $7,400 out of every $100 of the economy. By 2016, national health care spending is expected to reach $4.4 trillion, over 20 percent of our entire economy. Despite spending 1½ times more per person on health care than any other country, many of our people don’t even have health care coverage. Many of them are losing their coverage because of preexisting conditions or because it simply is costing too much. These costs are breaking the backs of our families and businesses. We can see here, single coverage, 1999, $2,196. Now at 2008, the last figures we have available, $4,704, a doubling. Family cost, 1999, $5,791—that is the average family’s premium—now they are paying $12,000.

Look what is happening to small businesses. A study by the Council of Economic Advisers found that small businesses pay up to 18 percent more than large businesses to provide health care coverage. In a recent national survey, nearly three-quarters of small businesses that did not offer benefits cited high premiums as the reason.

How do we do this? How do we get to the place where we want to go? We
must get our money’s worth from our health care dollars. The problem now is, we are paying too much and we are not getting a good return on what we pay. The solution must be to get the best value for our health care dollars; otherwise, we are going to need to take a look at the drivers of government spending and look to break havoc on the backs of government, businesses, and individual families.

Medicare is 57 percent of all Federal health spending. If we want to sustain Medicare, which we all do, to provide that high-quality health care our seniors deserve, we must do something to address the fiscal challenges.

The root of the problem is that most health care is purchased on a fee-for-service basis, so more tests, more surgery means more money. Quantity, not quality pays. According to researchers at Dartmouth Medical School, nearly $700 billion per year is wasted on unnecessary or ineffective care.

My favorite example is what Geling Clinic in Pennsylvania. They were not happy with their diabetestreatment, so they decided we are going to have the routine patients see nurses. The more difficult cases will see doctors or specialists. Then those endocrinologists will review the records of the nurses and make sure this patient is progressing as we want. Guess what. Patient quality goes way up because they see nurses and they see them more regularly. Results go way up because endocrinologists are spending time on the most difficult cases and reviewing records of the other. Costs go down $200 per month per patient. Guess what. They get paid less—way, way, way less for that kind of good quality care.

This system is messed up, and we need to change it so we are rewarding based on results. We put the patient in the driver’s seat so that when that patient gets better results, then we reward them. In Minnesota, we have several great examples of this coordinated outcome system.

At a place such as the Mayo Clinic, Park Nicollet, St. Mary’s in Duluth, the priority is value not volume. As this chart shows, if the spending per patient with chronic diseases everywhere in the country mirrored the efficient level of spending in the Mayo Clinic’s home region of Rochester, MN—this is Mayo Clinic quality health care.

For the last 4 years of chronically ill patients’ lives, if we used that same system all over the country, how much would we save, if we used this system in Texas, if we used this system in Florida? We would save $50 billion every 5 years for the taxpayers of this country and get higher quality care.

This is not like a hotel right now in this country where if you pay more money, you get a better room with a better view. No. The opposite is true. In this country, the States where you pay more money, you get less quality care. That is what we need to change to bring all of the States up to that high-quality care, efficient care, that costs less but is a better value. That is what we need to do.

How do we do it? Well, linking rewards to the outcomes for an entire payment area creates the incentive for providers to work together to improve quality and efficiency: using bundling, to bill, so you look at the whole outcome of everyone working together, so you rely on nurses when you want to rely on nurses, so you rely on doctors when you want to rely on doctors; by reducing hospital readmissions. Who wants to go back in the hospital over and over again just because there are a bunch of infections hanging around? In fact, right now, if you go back to the hospital, the hospital gets rewarded for that. So we want to put in place protocols that make hospitals safer places to treat patients. In 1 year, hospital readmissions cost Medicare $17.4 billion, and a 2007 report by MedPAC found that Medicare paid an average of $7,200 per readmission that was likely preventable. We need to have integrated care, where you have a primary care provider, working with a team, instead of having 15 specialists running around the field, running over each other. You need a quarterback, well, let’s just say like Brett Favre and the Minnesota Vikings. You have one quarterback who is your primary care doctor, who is in charge, with a team of doctors who look at all the medical records. That is integrated care. That is what we should be rewarding. That is what this bill does.

Looking at some of the other inefficiencies, the Presiding Officer has been a leader on Medicare fraud. Think about the money we can save. Medicare fraud alone costs taxpayers more than $60 billion every year. Instead of that money going to our seniors, do you know where that money is going? It is going to con men, people who are making up that they are providing services when they are not. The Presiding Officer and I have a bill we are working together on to bring that down so that money can actually go to our seniors instead of going out to a bunch of people who are ripping off the system, ripping off our seniors.

If you look at how you save money, if you look at how you reduce costs in Medicare, well, you reduce costs in Medicare by making changes to this system and making this work. We must look to the future. That is why health care reform this year is so crucial. This bill is not about today or even next year; it is about 5 years from now. It is about 10 years from now, and beyond. We cannot afford for the people of this country to hold off any longer. We can bring these costs down. We can bring the quality up. And we can reward the people of this country for the money they are putting into health care.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. DEMINT. Mr. President, I appreciate the comments of the Senator from Minnesota, who brought out a lot of important issues as far as the rising costs of health insurance, and I certainly knew that as a small businessperson. There is one only problem: The bill we are going to debate does not solve those problems. In fact, as CBO basically tells us, insurance will continue to increase at the same rate it does now, and for those with individual insurance policies, it is very likely to go up.

Mr. President, we are here on a Friday evening being told we are going to work through the weekend, maybe next weekend, all the way up to Christmas Eve, with the intent to rush through a bill that many have called—and I agree—one of the worst pieces of legislation and one of the biggest threats to health care we have ever seen here in this country. Apparently, the majority wants to rush this through and hope we can put it into law. In a way, it is like allowing it to go through by keeping us here on weekends over the holidays.

But I am proud Republicans are standing together against this bill and standing with the American people to stop the Democratic government take-over of health care in America and to stop them from paying for it by cutting nearly $500 billion from Medicare and raising taxes on millions of Americans.

I heard from one of our constituents, woman talking about Medicare and the cuts in Medicare, explaining very simply that Medicare is something he had paid for his entire 40 years of working out of his payroll taxes, and now he could not believe we were considering taking any money out of Medicare in order to pay for a new government program.

Americans work and pay for Medicare so that when they retire they will have benefits that give them the coverage they need. I think the majority may want to think Americans are paying attention or maybe even they are not real smart, that you can take $500 billion out of a program that is already bankrupt and expect the benefits to stay the same, when already we know our seniors and more and more physicians are not even willing to see Medicare patients.

If there really is waste and fraud in Medicare—and we know there is some—we should find it and put that money back into the Medicare system so we can keep our promises to seniors.

Every Democrat in the Senate has already voted for a government takeover of health care, to cut Medicare to pay for it, and to raise taxes. Some of them said they were just moving the debate forward. But I ask you, what debate? Will there be any serious consideration to take this government-run plan out of this bill? There will not be. As we have already seen there is no serious consideration to stop taking money out of Medicare to pay for it. In fact, we have had a lot of debate about
what this is going to do: to cut from Medicare, what it is going to eventually do to benefits, cut Medicare Advantage. Now we are talking about cutting home health, which is so important, particularly in rural communities and for the more elderly constituents we serve.

There is no way you could take this money out of Medicare without hurting the programs. Instead, as we look ahead at more people retiring than ever in history and Medicare being bankrupt, we are going to lose ways that we can shore up this program so it will be there for generations to come.

Every Republican voted no. Every Republican in this Senate has stood with the American people and said no to a health care bill that takes over the most personal and private part of our lives. I am proud of our party and our leadership.

Americans have been asking to see the differences between the Republican and Democratic Parties. I think now more than ever on this issue they are going to see the Democrats standing with government-controlled health care, cuts in Medicare, increased taxes and on the other side Republicans who are going to stay here through Christmas and New Year’s or whatever it takes to stop this bill and to sit down and really reform this system in a way that will lower costs and improve care to all Americans.

We need to continue to talk about these bigger issues, particularly how it affects Medicare, and we will be doing that over the weekend. But I think we owe it to the American people to begin to open this bill and explain what is in it. I can almost guarantee you, there is not one Member of the Senate who has read it yet. We are going to try to fit it in Santa’s sleigh this year so it will be delivered to every American.

I have the first part here—one, 1,000 pages, small print, front and back—and have been perusing through it, putting tabs on different pages, so we can talk about the different things because sometimes they sound so extraordinary, people do not really believe they are in there. I am not sure we will ever get through the whole thing, but I just want to take a couple parts tonight and just start talking about what is really in this bill.

On page 17, in section 2713 that is titled “Coverage Of Preventive Health Services,” which is really our jargon for rationing, it says:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for—

evidence-based items or services that have in effect a rating of “A” or “B.”

Well, just 2 weeks ago, we found out something that was not A or B. Mammograms are a C rating. And the task force came out and said it should not be covered on anyone under 50 years old. That is in the bill, that it would not cover mammograms for folks under 50 years old because it is not A or B. Because of the outcry, we had an amendment from the other side to give themselves a little bit of cover on that one medical procedure, mammograms. We passed it with some fanfare yesterday, but the fact is, there are going to be many C ratings that are not covered.

What are we going to do here in Congress over the next several years when we find constituents are not covered for things they need in retirement from Medicare? Are we going to pass bills to try to cover those individual things? What we should really do is throw out the bill that is causing the problem. We should not be rationing care to our seniors.

Let’s look at another page. And I know this is not as interesting as talking about theoretical stuff. But on page 33, section 2719 is called the “Appeals Process.”

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process . . . (to) provide notice to enrollees, in a culturally and linguistically appropriate manner.

Now, what do we think that means? Well, in fact, in 2001—this term has been used before—the Department of Health and Human Services reported that the Department had spent $10 million to figure out what that phrase means. And we still do not know. It says: “Health care services that are respectful of and responsive to cultural and linguistic needs.” But what this really means to us, according to the 2000 census, is there are at least 20 languages spoken by at least 200,000 Americans in this country, and what we are putting out there is a liability for every insurance company that does not have every aspect of their plan in those 20 languages. It may sound like a simple thing, but every page of this bill, almost—as you read it, you realize it is increasing the complexity and the cost of the system here in America.

I will just cover one more of these because I hear my colleagues in the background urging. But I do think we owe it to the American people to begin to talk about what is really in this bill.

On page 39, it says, under a funding category:

Out of all funds in the Treasury not other than Medicare, the Secretary $250,000,000 to be available for expenditure for grants under paragraph (1) and subparagraph (B).

Those subparagraphs are to track the trends in premium increases of health insurance once this bill goes into effect. Mr. President, $250 million to do what the Congressional Budget Office has already told us are going to be increases. But this kind of spending and this type of bureaucracy and complexity we are creating is not going to make health care more accessible and more affordable for Americans. It is creating a complex bureaucracy with thousands of workers and bureaucrats to tell doctors what to do and hospitals what to do and for us, how to manage our health care.

The Congressional Budget Office has already released a report finding that the proposals for purchasing insurance through the health insurance exchanges that are in this bill could pay up to 16 percent more for health care than we do today. Yet we are moving ahead with the bill.

I will continue throughout this weekend, and every time I get a chance to speak, to talk about more of these things that are in this bill. But, folks, this is not a bill we should deliver to the American people for Christmas this year. This is a bill we should throw out so we can start over and have a step-by-step approach to make health insurance more affordable and available to every American.

With that, Mr. President, I yield back.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I think we are going to go back and forth here. Mr. ROBERTS, there is no “forth.” Mr. BAUCUS. Sorry.

Mr. ROBERTS. There is no “forth.” Mr. Chairman.

Mr. BAUCUS. Well, we are going to go back and forth. Here is Senator KRAUSS.

Mr. ROBERTS. We could go back and back, sir. I do not care—and then forth and forth.

Mr. BAUCUS. Back and forth, and forth and forth, and to and fro, and this and that and it works fine for me.

The PRESIDING OFFICER (Ms. KLOBUCHAR). The Senator from Delaware is recognized.

Mr. KAUFMAN. Madam President, I ask unanimous consent to speak in morning business for up to 5 minutes.

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

(The remarks of Mr. KAUFMAN are printed in Today’s Record under “Morning Business.”)

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Madam President, I rise today in support of the motion of my good friend from Nebraska, my colleague from Nebraska, Senator JOHNSON to—the official words say: to commit the bill back to the Senate Finance Committee with instructions to strike the cuts to the Medicare home health care benefit.

What the distinguished Senator is trying to do is bring some common sense to the cuts to a very vital source of health care, not only to rural areas but all over this country, and that is home health care. The bill we are considering, the bill sometimes called the
smokescreen in this whole debate. It may be true that this bill does not explicitly cut benefits. My friends across the aisle, however, cannot deny that their cuts in reimbursements to providers will affect those benefits, because you cannot cut the reimbursements to providers, guarantee who pays the price. The patients—Duane and Phyllis and their little dog Josie. I tell you what. You come to their house and you make that argument that if you close down or make cuts to home health care, Duane would like to like it, Phyllis is not going to like it, and Josie will bite you on your leg.

As I said, many of my Kansas home health care agencies already operating at negative margins. Their portion of these cuts, as provided by the distinguished Senator from Nebraska, is almost $240 million. To the Senator from Montana, the distinguished chairman of the Finance Committee, my dear friend, that is $60 million in reimbursements to the state where the distinguished majority leader lives, the chart that has been provided to me by the Senator, $263 million. We have Senator CORNYN sitting right behind me here. Senator CORNYN, do you have any thoughts for Texas. I might ask the Senator, what is going to happen if you get cut $6.8 billion in regard to home health care service?

Mr. CORNYN. If the Senator will allow me, the Senator from Nebraska has already pointed out what happens in Nebraska, and I know what will happen in Kansas. Nearly two-thirds of Kansas home health care agencies will have negative margins within only 5 years, probably 2 or 3, if these cuts are allowed to occur.

How are these agencies supposed to stay in business with these kinds of cuts? The home health care benefit will be worthless to a Kansas Medicare payment. Home health care agencies will have negative margins within only 5 years, probably 2 or 3, if these cuts are allowed to occur.

Thank you, Senator JOHANNS. Thank you for the work you are doing. Thank you for this motion. I hope we are successful. I hope people will wake up and understand the severity of what these cuts will do. I urge every Member of this Senate to support Senator JOHANNS when we come to a vote on this issue.

Thank you, Mr. President. I yield the floor. The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have heard a lot here today about how this is going to hurt seniors and so on and so forth, words such as "smokescreen." The fact is there is no smokescreen here whatsoever. This is a very well thought out, considered policy that I think strikes a very good balance between getting care to especially seniors at home, which is so important on the one hand, and making sure there is not waste on the other hand. That is our responsibility here. Make sure the program works and works well.

I have sort of a special interest in this. My mother was in the hospital. It happened about 2 weeks ago. She fortunately is doing much better. She has spent some time with a home health caregiver with whom I was very, very impressed. This home health person is doing a great job with my mother. I have seen other instances too, but personally I was very happy to see my mother getting very good care from a home health nurse.

I think it is also important to remind my colleagues that this amendment is generally a retread on the McCain amendment we debated over the last few days. That is, once again, the opponents of this bill are endorsing the status quo that leaves Medicare on the brink of going bankrupt and seniors facing higher costs.

Let me remind my colleagues again what will happen if we stick with the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. That is the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. That is the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. That is the status quo.

Thank you, Senator JOHANNS. Thank you for your comments. Thank you for those thoughts. I yield the floor.
waste. I am quite surprised not all of our colleagues want to cut out the waste. In effect, they want to keep the waste that, unfortunately, is in our system.

The status quo also means each year billions of Medicare dollars will continue to be wasted on lining the pockets of private insurance companies. That might be a bit of a strong statement, but the fact is, some chief executives of private insurance companies are padding millions of dollars to manage Medicare Programs, especially Medicare Advantage, and the status quo means that will continue.

The status quo also means seniors will continue struggling to pay for prescription drugs. The stakes for seniors in the Medicare Program have never been higher.

We have a choice. It is a very simple choice: either endorse the status quo or strengthen Medicare. Regarding Medicare changes for home health providers, let me describe what is in the Senate bill. I don’t think our colleagues know specifically what is in the Senate bill. That may be a strong statement to make. But if they knew what was in the bill, I think some of the statements made tonight might be a little bit different.

As most of my colleagues would agree, home health care is an extremely important benefit in the Medicare Program. We are all very strong advocates of home health care. Across the country, there are more than 3,800 home health agencies providing care to seniors in their homes. This helps seniors get better and helps them to avoid expensive rehospitalizations.

We are all champions of home health care. We would like fewer people not to be institutionalized. It is much more appropriate to have care in the home, and home health agencies provide that.

In Montana, home health care providers go the extra mile—literally—to provide care to patients across vast distances. In some cases, in rural areas they have to drive 100 miles just to see one patient. They are dedicated people. They go great distances and travel a long way to see very few patients.

Home health providers make a real difference in improving seniors’ health, and we should support their efforts. We all very much support their efforts.

What I have great respect for is the services of home health providers, we also have a responsibility to protect the Medicare Program. Unfortunately, there is almost always waste somewhere. It is a matter of judgment as to how much is waste and how much is not.

We must make sure Medicare is paying appropriately; that is, that Medicare is not overpaying for Medicare services. We must take action to root out fraud and abuse in the Medicare Program generally and where it may occur in the home health industry as well.

I think the policies in the Senate bill achieve both goals. First, the Senate bill would “rebase” home health payments to ensure payments reflect actual costs of providing care. These changes are based on recommendations by Medicare’s independent advisory commission that advises Congress on Medicare reimbursement. It is a nonpartisan group. MedPAC advises that we rebase. What do we mean by “rebase”? When the current home health payments were set, seniors received an average of 31 visits per episode. Today, they receive 22 visits; that is, they get paid about the same for doing less. We are trying to make sure the payment reflects the actual services provided.

The Senate bill directs CMS to rebase payments to reflect this change. It is common sense. MedPAC recommended it and thinks it has to keep up with the times. Times have changed over the years, and the payment system should reflect that change.

There is something else I think is pretty important, and most of my colleagues would agree, the Senate bill roots out fraud. Unfortunately, exist in home health care as well as in other areas of Medicare spending. It tries to root out the fraud in Medicare payments for outlier cases. Medicare provides an extra payment today for providers—home health folks—who treat sicker people, otherwise known as outlier patients—really sick, outliers. Unfortunately, the GAO found that some providers were gaming the system and getting much more outlier payments than they deserved.

For example, the GAO found that in one Florida county alone, home health providers were receiving 60 percent of all total outlier payments. That is nationwide. One county was getting 60 percent, even though they had less than 1 percent of the total Medicare population. I don’t want to just single out Florida. Other counties in the southern part of the country clearly have a disproportionate amount of high outlier payments.

The Senate addresses this problem by placing a cap on the amount any individual provider can receive in outlier payments.

Another change is the bill makes market basket changes in 2011 and 2012. That was recommended by MedPAC. Why is that important? MedPAC is actually much tougher. On the market basket and productivity changes, the Senate bill holds off on applying these reductions while the rebasing policy is taking effect.

This bill gives home health agencies extra time—much more time than is recommended by the very aggressive proposed changes by MedPAC, the House bill, and the administration. We say those are too aggressive. We in the Senate decided to give agencies extra time to adapt to the payment changes in the bill rather than having all these changes implemented at the same time as MedPAC and the House and the administration all recommended.

Finally, with respect to rural home health providers, we are all very sensitive to the special needs of rural America. What did we do about that? From 2010 to 2015, rural providers will receive a 3-percent extra payment each year. This payment will ensure that rural providers are protected as we reform the home health system.

In total, the home health changes in the Senate bill give agencies extra time to adapt to the changes over time rather than all these changes implemented at the same time. But the home health providers support this phase in. They think it is a good idea.

On the outlier policy and the fraud changes, these policies were actually suggested to us by—guess who—the home health industry. They came to us and suggested we make some changes in outliers because too many agencies are gaming the system. They asked us to make some outlier changes and stop that gaming, to make changes to stop the fraud. They came to us and gave us some ideas. Obviously, the home health industry fully supports the changes they recommended to us. They are in this bill.

On the market basket and productivity changes, the Senate bill holds off on applying these reductions while the rebasing policy is taking effect.

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That is AARP. I don’t suggest tonight that any of our colleagues are using myths and misinformation to distort the truth. The point is, AARP claims that is not true. They support the bill strongly.

I will remind my colleagues of some of the positive changes in the legislation. This legislation improves the solvency of the Medicare Program by 5 years. It puts $30 billion back into the pockets of seniors in the form of lower Medicare premiums. It makes prescription drugs more affordable, which is an added benefit in this bill that would not be available if the legislation is not passed. The bill guarantees that seniors can continue to see a doctor of their choosing. The bill provides for wellness and prevention benefits. Those are new benefits. They don’t currently exist. It will also include fair and appropriate changes for home health that protect access to care.

I don’t question the motives of my colleagues. They believe they are standing up for seniors in opposing the home health changes. But in truth they will harm them because they are hurting the Medicare Program. We are trying to help the Medicare Program by making these changes.

There is one other point I want to make. This is kind of interesting. I thought when I saw it—if I still have it—it is kind of interesting. The growth rate in home health care spending will continue to be very high after this legislation passes. Currently, the growth rate of the home health care industry is almost 11 percent per year. After the legislation, it will be almost an 8-percent annual growth in the home health care industry. That is much faster than the national health expenditures.

I think most things in life are a judgment call. I think one fairly decides that the changes in this bill are good for seniors and home health care providers are sensitive to patients, frankly, but also sensitive to their pocketbooks. We need to set the record straight on this. I think the biggest mistake about the way this bill is paid for, with the huge tax increases and huge cuts in Medicare, is the proposal to take $1 trillion out of Medicare and it would not have any impact on the delivery of services to Medicare beneficiaries—$1 trillion.

I think the biggest mistake about the way this bill is paid for, with the huge tax increases and huge cuts in Medicare, is the proposal to take $1 trillion out of Medicare, including $10 billion out of home health care, in order to pay for a brandnew entitlement program, when we already know Medicare itself is on a fiscally unsustainable path.

I want to talk primarily about another aspect of these cuts, and that is the 11 million seniors, including 532,000 Texans, who will lose benefits under their Medicare Advantage Program because these are not inconsequential cuts. These are serious. I want to talk about some real human beings, some real Texans, who are going to be affected in a negative way by these cuts. First of all, I think it is absolutely critical for American people to understand that Medicare itself does not provide complete coverage to seniors. That is why so many seniors end up buying supplemental insurance coverage—Medigap coverage, as it is sometimes called—in order to get their bills paid. Medicare only pays, on average, about 80 percent to providers of what private health insurance does.

That is the reason, without additional compensation, many doctors will not see a Medicare patient. They simply cannot do it and keep their doors open to their other patients. The truth is, Medicare Advantage was created to fix some of the flaws within the original Medicare program. I don’t think we want to hurt the Medicare Program. We are trying to help the Medicare Program by making these changes.

On balance, it makes things worse than it does better because of these cuts in things such as Medicare Advantage. The President of the United States has said providing Americans with a choice of quality, affordable healthcare was a guiding principle for him. I agree with that statement of principle. Medicare Advantage was created for that very purpose because, as I said, Medicare itself does not always work well for patients.

Where I live in Austin, TX, which is Travis County, the last time I saw a report, only 17 percent of physicians will participate because the payments by Medicare reimbursement rates are so low. Those problems are avoided in large part by Medicare Advantage because it pays physicians and providers better than Medicare fee for service.

According to the American Medical Association’s 2008 national health insurance report card, Medicare—not private health insurance—but Medicare had the highest percentage and the largest number of denied medical claims. In fact, Medicare denied 10 times more medical claims than private health insurers. That is another reason why seniors deserve a choice between Medicare and private plans that will offer half of the additional benefits. As I mentioned, today, 11 million Americans made that choice of better benefits and better care coordination through the Medicare Advantage Program. The proposed bill, the Reid bill, will take away those choices and the benefits of those 11 million seniors by cutting about $120 billion from the program.

Many of our friends across the aisle will say we can cut $120 billion out of Medicare Advantage, and it will have no impact on delivery of services. But the Director of the Congressional Budget Office disagrees with them, who says their additional benefits will be cut roughly in half.

We need to set the record straight on these so-called overpayments allegedly going to insurance company profits. It is simply a false statement. It is not true. Our colleagues know the so-called overpayments to Medicare Advantage plans do not go into those plans. They go to seniors in the form of additional benefits. That is because, under Federal law, 75 percent of additional payments to Medicare Advantage plans are used to provide seniors with additional benefits—benefits which they would not get under Medicare fee for service, benefits such as chronic care management, hearing aids, eyeglasses, and the like. The other 25 percent of any extra payments is returned to the Federal Government.

Let’s be clear. Cuts to Medicare Advantage would be taking away seniors’ health care benefits for those 11 million seniors. As I mentioned, approximately half of the additional benefit would be lost to those current Medicare Advantage policy holders.

Direct Elmdorf: For those who would be enrolled otherwise under current law, yes.

Nearly one out of every four seniors in Texas would lose about $122 a month in health care benefits to create a new $2.5 trillion entitlement that their grandchildren will ultimately have to end up paying for. And $122 a month may not sound like a lot for people in my situation, but people from my hometown of San Antonio recently wrote to me:

Please vote to leave our Medicare Advantage plans alone. We can’t afford anything else as our portfolio was wiped out in the stock market collapse last year. My wife and I have had to go back to work, and we are in our seventies.

Yet this bill would impose another $122-per-month cut in their benefits.

Another constituent of mine from Conroe, TX, wrote:

Please do what you can to protect the Medicare Advantage plans. I’m on one and it has been beneficial to me. It has saved me an enormous amount of money and given me the benefits I’ve needed.

Some groups that support these cuts to Medicare Advantage have a conflict of interest, to say the least, because the benefits under traditional fee for service, as I mentioned, for Medicare is a significantly better option than private insurance will pay. In order to get coverage, in order to pay the bills, many seniors have had to buy additional insurance
Kelsey-Seybold in Texas. But private sector innovators have been doing this through the Medicare Advantage Program already.

The delivery system reforms in the Reid bill would allow Medicare to experiment with new approaches to changing physician incentives, such as accountable care organizations or physician quality reporting initiatives. Will they work? I happen to think they will. What private sector innovators have already figured out how to change physician incentives in the sort of ways we ought to be doing more of and not punishing by cutting Medicare Advantage.

One Medicare Advantage plan, HealthSpring, serves 20,000 seniors in my State. They have been a leader for changing incentives for physicians to focus on quality rather than quantity. I met with their leadership and heard they had increased mammograms by 246 percent, foot exams by 360 percent, and flu vaccinations by 214 percent. Preventive measures increased and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits. They said: "We have had the Medicare Program around for more than 40 years. The fact is, government bureaucrats are still trying to get the complex reimbursement formulas right. We know, as the distinguished chairman of the Finance Committee has said, that under the fee-for-service program, which is part of what needs to be reformed in this health care bill, Medicare pays for volume and not value."

"The irony is, Medicare did not think of coordination of care and evidence-based quality standards, and ultimately lower health care costs, which I thought was supposed to be one of the goals of health care reform. Participating physicians were paid financial incentives for meeting their goal, but as a result of coordination of care and evidence-based quality standards, they actually ended up charging less and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits.

The results are a win-win: better quality care leading to healthier seniors and physicians who succeed in meeting evidence-based quality standards and ultimately lower health care costs, which I thought was supposed to be one of the goals of health care reform. Participating physicians were paid financial incentives for meeting their goal, but as a result of coordination of care and evidence-based quality standards, they actually ended up charging less and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits.

We will call him Ed—Ed’s immune system and left him susceptible to infections. One morning in 2001, he lacked energy to even get out of bed. His breathing became labored. He developed a cough that sounded "whooping." His worried wife called his primary care physician at WellMed, Dr. Marlene Sanchez, who wanted Ed hospitalized immediately so she could order a nuclear scan of his lungs. He protested.

"She told me that if he refused to go, I should call 911 and have the paramedics come get him," [his wife] Annette recalled. "He heard Dr. Sanchez talking to me, the urgency in her voice, and that convinced him to go.

The scan confirmed Dr. Sanchez’s suspicions: A potentially fatal blood clot had traveled from Ed’s leg to his lungs. He was successfully treated and recovered. [Ed and his wife] recently celebrated Ed’s 74th birthday.

Annette credits Dr. Sanchez for saving Ed’s life and for acting as a catalyst that keeps him thriving in their golden years.

"We have seen an abundance of doctors, from the cancer doctors to the dermatologist, gastroenterologist, the blood doctor, the heart specialist—Ed has gone through it all...and they’ve all been coordinated by his primary care doctor; I’ve been to other hospitals outside WellMed and you don’t get the feeling that they are communicating like this."

Well, many Texas seniors currently enjoy these extra benefits under Medicare Advantage, such as—another benefit—the Silver Sneakers program, the nation’s leading exercise program for older Americans. This past year, one of the Silver Sneakers members personally visited my office to deliver testimonials from other Silver Sneakers members. One Texan said:

"At my age I need a program to strengthen me, not make me weaker. I need this program with my stability and coordination. I need these skills to keep me from falling and breaking my bones."

Another participant in the Silver Sneakers program said:

I am 66, have been in the Silver Sneakers program a year. Prior to that I led a sedentary life, which included many health problems. I had hypertension, high cholesterol, chronic bladder condition, and mild depression. Since coming to classes and utilizing the weights and cardio machines, my life has improved immensely. My blood pressure has dropped, my cholesterol has been
lowered, my chronic bladder condition has improved and I just feel better all around. I am no longer depressed because I look better and look forward to going to class and visiting my friends.

These cuts in Medicare Advantage are going to have a direct impact on the benefits my constituents in Texas are benefiting from—the 532,000 Texans who are currently on Medicare Advantage—and what they are asking me—which I can’t answer—is why in this world would we want to cut Medicare Advantage, which actually works, as opposed to Medicare fee for service, which does not work well? Why would we take a fiscally unsustainable program, such as Medicare, which is going insolvent in 2017, and use that to create a $2.5 trillion new entitlement program?

My constituents, the seniors who have paid into Medicare all these years, are saying: It is not fair to take the money we have paid into Medicare and use it to create yet another entitlement program and not to fix Medicare itself. So I believe we need to fix Medicare’s nearly $38 trillion in unfunded liabilities. We need to fix the improper payment rate of roughly 1 out of every 10 Medicare dollars which results in somewhere on the order of a minimum of $60 billion of fraudulent payments each year. We need to put it on a fiscally sustainable path, rather than asking $5 trillion from Medicare for another ill-conceived Washington health care takeover.

I don’t believe my constituents believe you can take $1 trillion out of Medicare Advantage, and it will have no impact on their benefits. They don’t buy it. They don’t believe it, and I don’t either.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, it is late in the evening. I was going to address three different issues tonight, but out of respect for Senator BAUCUS, the chairman of my committee, I am going to address just one of these issues and I will come back tomorrow morning, on Saturday, and speak on the rest of the issues.

The one issue I am going to address this evening is my support of the Senator from Iowa and his motion to commit with instructions on the home health care aspect of this 2,074-page bill. That is Senator JOHANNS’ motion. We are now considering a bill that cuts $5 trillion from a Medicare Program to fund yet another unsustainable health care entitlement program. Around $42 billion comes from cuts to home health care providers—hence the purpose of Senator JOHANNS’ amendment that that not happen.

You are heard from Members on this side of the grave consequences of these cuts. Several Senators have already addressed these. These severe cuts pose a legitimate threat to beneficiaries’ access to home health services. In my State of Iowa alone, there are around 160 home health agencies that provide valuable services to Medicare beneficiaries across the state. Thanks to these home health care providers, seniors in Iowa are able to live at home, in non-institutional settings, such as nursing homes. These seniors place great value on being able to stay in their homes. I would have to say that in all the years I have been involved in senior issues, whether it has been on the Finance Committee, or chairman and now ranking member of the Finance Committee, I haven’t run into one single senior citizen in my State who said to me: I am just dying to get into a nursing home. They do not want to go there.

So that is the purpose of home health agencies, to save money, but it is to retain the quality of life, and maintain the quality of life for these citizens. I rarely hear Iowans say anything about living in a nursing home, except not to go there.

Since living at home has been found to be a more cost-effective alternative than institutional care, this results in Medicare spending less. These cuts that I have in the 2,074-page Medicare bill will make it even harder for Iowa home health care providers to care for Medicare beneficiaries. A good part of the Medicare home health cuts come from permanent productivity adjustments. Let’s talk about productivity.

I would say I have concluded the imposability—of bringing greater productivity to nursing home care. You have heard this week about how Medicare’s chief actuary found savings from these productivity adjustments to be very unrealistic. And just so you know that the letter I refer to from the chief actuary is real, observe this chart. You also heard this week how these permanent cuts would make it harder for providers to stay solvent. You also heard these providers might end their participation in Medicare and possibly then jeopardize access to care for beneficiaries, and probably then more people ending up in the more expensive environment of a nursing home.

The threat to access to home health care from these permanent productivity cuts isn’t theoretical. It is real. Like many other Medicare providers, home health agencies provide labor-intensive services. And I do not mean just those labor-intensive services that I raise the question and the possibility—and I say it ends up being an impossibility—for them to be more productive. There are a few gadgets in home health that will increase productivity. And whatever available gadgets there are, they are unaffordable for many Iowa home health agencies because they are small operations with limited financial resources.

Home health care is about doctors, it is about nurses, and home health aides, and it is about all of these providing care to the most needy. So it is incorrect, in my judgment, to assume these providers will achieve the levels of productivity like the rest of the economy.

The HHS chief actuary’s findings clearly apply to home health in my State of Iowa, as they do nationally. Just to remind you: “The estimated savings may be unrealistic,” and “possible participation in Medicare and possibly then jeopardizing access to care for beneficiaries for our seniors.” More people in nursing homes.

Because of these cuts, the percent of Iowa home health agencies that have negative Medicare margins will increase from 72 percent over 120 of the 160 home health providers will have negative Medicare margins because of this 2,074-page Reid bill. Iowa providers are not alone. From ½ to 90 percent of home health agencies in States across the country would have negative Medicare margins.

I ask a unanimous consent to have printed in the RECORD three letters, which I wish to put in at various places in my remarks.

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

Mr. GRASSLEY. Mr. President, I have here a letter dated September 23 of this year from Val Halamadaris, the president of the National Association for Home Health and Hospice. This organization represents home health agencies across the country.

Mr. President, Mr. Halamadaris wrote this letter in response to the $43 billion in home health cuts in the Finance Committee package, which presumes to be the same number that is used in the Reid bill. In this letter, he stated:

It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee’s health reform package. Our analysis indicates that by 2016, 67 percent of home health care services payment rates will lead to nearly 70 percent of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama’s promise that Medicare beneficiaries will not be adversely affected by health care reform will be broken.

I have yet to hear from a home health care provider in Iowa that these permanent cuts will make it easier for them to care for their Medicare beneficiaries. Instead, I hear these cuts would reduce access to home health services.

The second letter I asked to have inserted in the RECORD is from the Iowa Alliance in Home Care, and they wrote:

Ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services for many Iowans who prefer to receive services in their home.

Not only is the chief actuary saying it, as the chart reflects, but people who are connected with the business of home health care are saying it. These permanent cuts will in fact jeopardize access to home health services in Iowa. So if the home health cuts in the bill are allowed to go into effect, then
Iowa’s seniors, who prefer to live full lives from their homes, will be forced to live in the more expensive settings of facilities such as nursing homes. I believe many Members on both sides of the aisle share my concern about these cuts.

I have here a third letter, this one dated from July 27, 2007, and it is written to Senator BAUCUS and me.

Mr. President, I use this letter, even though it is 2 years old, because we were getting enrollees from 61 of our colleagues—of which 52 now still serve in the Senate—about a legislative proposal to cut Medicare home health payments in that year—2007—by $9.7 billion and hospice payments by more than $1.1 billion. They urged me and Senator BAUCUS, at that time, to ensure that home health and hospice providers receive full market basket inflation adjustments. They also urged us to oppose any cuts in payment rates through administrative action.

In these letters, these Members stated that home health and hospice care “have been demonstrated to be cost-effective alternatives to institutional care in both Medicare and Medicaid programs.” They stated that “reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk.”

Of these 61 Senators who signed this letter 2 years ago, 52 are currently here debating this bill in the Senate. Of those 52 Senators, 37 are from this side of the aisle who are now proposing $43 billion in cuts instead of $9.7 billion in home payment cuts and $1.1 billion in hospice payment cuts. I would think they would find these kinds of cuts three or four times—four times—what we were talking about 2 years ago to be very unrealistic, and to keep home health as a viable organization going.

We get feedback from you and your colleagues outside of this health care when we look at the impact of these permanent cuts. I have also heard from providers in Iowa that permanent cuts such as these will make it even harder for them to keep their doors open. So around 3,500 Iowans who work at home health agencies are at risk of losing their jobs at a time when we have 10 percent unemployment, at a time when more of this country is concerned that Congress ought to be working on jobs, jobs, jobs as opposed to the health care issue and in some cases cutting jobs out. The Labor Department reported today that unemployment is 10 percent. Now is not the time to consider bills that increase unemployment rates.

About an hour ago, the Senator from Nebraska offered this motion I am speaking in favor of now, to send this bill to the Finance Committee with instructions to report a bill without these very enormous home health cuts that are in it. We should take this opportunity to fix the bill and then come back to the full Senate with a better bill. That is why I support the motion of the Senator from Nebraska to commit, and I urge my colleagues to do the same.

I yield the floor.

**Exhibit 1**

**National Association For Home Care & Hospice**

**Washington, DC**

**DEAR SENATOR GRASSLEY:**

I am writing to thank you for your continued support of home care patients nationwide and to enlist your help to ensure that access to home health and hospice services remains a reality for more than 5 million senior and disabled individuals that benefit from these important services.

It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee’s health reform package. Our analysis indicates that by 2016, the proposed cuts in home health services payment rates will lead to nearly 70% of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama’s promise that Medicare beneficiaries will not be adversely affected by health care reform efforts will be broken.

Invariably, providers of services facing rate cuts always cry out that care will be lost. However, history tells us that our warning should be heeded. The Balanced Budget Act of 1997 was expected to cut home health services spending by $16.1 billion in five years. Instead, the rate changes cut over $70 billion, leading to the loss of care to nearly 1.5 million Medicare beneficiaries. That change also led to higher outlays under state Medicaid programs, as well as greater use of nursing homes, hospitals, and other institutional settings. Still today, about $17 billion is spent on home health services, as compared with about $19 billion in home health outlays in 1997.

Several factors need to be understood about the current Finance Committee proposal. First, it is not consistent with MedPAC advice. The proposal reduces rates to a point where Medicare margins will average zero. MedPAC, in its deliberations, clearly recognized some level of margin in order to stay in business. In fact, we understand that MedPAC’s executive director, Mark Miller, informed House Ways and Means members that MedPAC did not recommend a zero margin.

Second, there is a serious misunderstanding of Medicare margins. MedPAC estimates margins for 2009 will be 12.2%. However, this estimation does not include the impact of nearly 7% in rate reductions planned by way of regulation by 2011. Further, it does not include nearly 1% of the margin in order to stay in business. In fact, we understand that MedPAC’s executive director, Mark Miller, informed House Ways and Means members that MedPAC did not recommend a zero margin.

Third, unlike other health care providers such as hospitals, the expansion of home health insurance will result in any material level. Home health patients average nearly 80 years of age and are already insured by Medicare or Medicaid. This means that Medicare payment for even small reductions in Medicare payments to home health providers would have no meaningful increase in home health care business.

This is a historic time in this country, an opportunity to secure health care for all as a fundamental right. Reforms should not be done at the expense of our most vulnerable senior citizens, the home-bound and infirm. Your leadership on this issue is greatly appreciated. Please let us know what we can do to help you succeed.

You have my great respect and admiration, now and always,

Sincerely,

VAL J. HALAMANDARIS, President.

**Exhibit 2**

IOWA ALLIANCE IN HOME CARE,

Des Moines, IA, December 4, 2009.

**RANKING MEMBER, COMMITTEE ON FINANCE, DURKSEN SENATE OFFICE BUILDING, WASHINGTON, DC.**

**DEAR SENATOR GRASSLEY:**

I’m contacting you today to urge your assistance concerning an issue of great significance to Iowa’s dedicated home care nurses and other providers of valued and needed in-home health care services to Iowans. The Iowa Alliance in Home Care respectfully requests your support to have the Senate Finance Committee report back to the Senate, in response to a bipartisan report with instructions in H.R. 3590 bill that does not include cuts in Medicare payments to home health agencies totaling $21.1 billion.

Your urgent action is critically important to ensure that access to quality health care services delivered in the home setting is not compromised. Proposed cuts in Medicare home health care and reimbursement would be devastating as most of Iowa’s home care providers (i.e., public health departments, small businesses) rely largely or exclusively on Medicare and Medicaid payment to justify their operations which are critical for the reimbursement for thousands of Iowans. Insufficient Medicaid home health reimbursement, recently worsened by Governor Culver’s ATB state budget cuts, has been reduced by an additional 5% effective 12/1/2009. In short, ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services access for many Iowans who prefer to receive services in their own home.

Senator, thank you for your past home health care support. We greatly appreciate your immediate attention to this most critical of needs for our Iowa home health care community.

Sincerely,

MARK WHEELER, Executive Director.
The use of technology, like telehealth monitors, which is not covered by Medicare; the need to pay significantly higher salaries for nurses, therapists, and home health aides to attract these individuals from the scarce supply of clinicians nationwide. Many home health agencies currently do not have a sufficient number of clinical staff to accept patient referrals from physicians and hospitals. A consequence, hospital discharge planners who believe that they are finding it more difficult to refer patients for home health care. Additional cuts to the home health benefit could leave home health providers no alternative but to reduce the number of visits and/or patient admissions, which would ultimately affect access to care and clinical outcomes. In addition to these costs, the market basket update, which rising costs for pain management pharmaceuticals, and they are also finding that patients with shorter lengths of stay are requiring more intensive services.

In order to ensure that home health care and hospice remain a viable option for Medicare patients, we urge you to support full market basket updates for home health and hospice, as provided under current law, and to oppose any cuts in payment rates through administrative action. Thank you for your consideration of this important matter.

Sincerely,

Susan M. Collins; Russ Feingold; Christopher J. Dodd; Kay Hagan; Max Baucus; Patrick J. Leahy; Arlen Specter; Norm Coleman; Sheldon Whitehouse; Robert Menendez; Ken Salazar; Barack Obama; Kent Conrad; Barbara Mikulski; Joe Lieberman; Benjamin Nelson; Daniel K. Inouye; Tom Harkin; Robert C. Byrd; Frank Lautenberg; Amy Klobuchar; Herbert Kohl; Byron L. Dorgan; Daniel K. Akaka; Barbara Boxer; Tim Johnson; Johnny Isakson; Evan Bayh; Jim Webb; Patty Murray; Christopher J. Dodd, Jr.; Dick Durbin; John F. Kerry; Hillary Rodham Clinton; Sherrod Brown; Christopher J. Dodd; John Thune; Carl Levin; John W. Warner; Saxby Chambliss; Ron Wyden; Mark L. Pryor; Maria Cantwell; Robert F. Bennett; Bernard Sanders; Charles E. Schumer; Richard G. Lugar; Diane Feinstein; Larry E. Craig; John Cornyn; Benjamin L. Cardin; Edward M. Kennedy; Pete V. Domenici; Bill Nelson; Susan Collins; Lisa Murkowski; Richard J. Durbin; Pat Roberts; John E. Sununu; Mary Landrieu; Sam Brownback.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, before the Senator leaves, he is a man of great character and experience in these matters.

I have a letter from a constituent who writes to urge a vote against this health care bill. This is from Mr. Bill Eberle in Huntsville, AL. He says:

The worst part of this bill is that much of the cost will be paid for by cuts to Medicare.

I think the Senator has indicated he believes that is accurate.

He goes on to say:

I am 68 years old and I have paid into Medicare all my working years before he retired—that now, with Medicare already being in jeopardy, based on the trustees’ report which says that by 2017 there is not going to be any money in the trust fund, and then having $464 billion taken out of that fund, which helps finance a new entitlement program at a time when the present entitlement programs are in a great deal of financial jeopardy.

Mr. SESSIONS. I think you stated that very well. Just to reemphasize, this gentleman, Mr. Eberle, who paid into Medicare for 40 years, until he got to be 65, he got not a dime of Medicare benefits. He worked before he retired—that now, with Medicare already in jeopardy, just to reemphasize.

Mr. SESSIONS. My constituent, then, is fundamentally correct in his concern.

Mr. GRASSLEY. I sense a great deal of resentment coming through in that letter, from the words of that letter from that person, that what he has paid into, for the probably 45 years of working before he retired—that now, with Medicare already being in jeopardy, based on the trustees’ report which says that by 2017 there is not going to be any money in the trust fund, and then having $464 billion taken out of that fund, which helps finance a new entitlement program at a time when the present entitlement programs are in a great deal of financial jeopardy.

Mr. SESSIONS. I think you stated that very well. Just to reemphasize, this gentleman, Mr. Eberle, who paid into Medicare for 40 years, until he got to be 65, he got not a dime of Medicare benefit, did he?

Mr. GRASSLEY. No. The only way he would have gotten benefits is if he had become disabled before age 65.

Mr. SESSIONS. He pays into it all these years and just now gets to draw it, and people start taking it out. I thank Senator GRASSLEY for his leadership on this issue. I think he and I come out of the soil of our States, out of the real world. My impression is that nothing comes from nothing. Would you agree? Somebody has to pay for it.

Mr. GRASSLEY. I say it this way. We are in a town where we are dealing with a lot of Washington nonsense, and I hope, from the rural areas of Alabama, like the State of Iowa, you bring a lot of common sense to this town where there is not a lot of it.

Mr. SESSIONS. I thank the Senator. I would say the matter is a very serious one we are dealing with. Today, I had the opportunity to talk to a very experienced person involved in health care issues for many years. I expressed my bafflement about some of the disagreements we have, about huge issues.
One of my staffers wrote down what he said. He said: “In all my years I have never seen such transparent dishonesty in the Congress.”

He said: “It is the biggest fraud that has been perpetrated in the history of our country,” in his opinion.

Here is what I want to say I am going to pursue this in a little more detail. I am not going to go into great length tonight. But we have an amendment—Senator Bennet offered an amendment yesterday that said we wouldn’t cut guaranteed benefits for Medicare. But the way this deal is being done is they are cutting payments to providers of Medicare.

We are already reaching, as Senator Grassley said, a national crisis because by 2017 we will not be able to have a surplus in Medicare, we are going into default in Medicare. Where are we going to get the money?

Could we have efficiencies? Could we save in Medicare? Could we do some things to keep the program afloat? Perhaps. But if we do so, should not we use it, should not we use any efficiencies in savings that we could scrape together without damaging the commitment we have to our seniors—should not we use those savings to pay for Medicare that is going into default? I suggest that is a moral and legal commitment.

Mr. Eberle has written to me. He has paid for 40 years. He has not been able to draw on it. I think Senator Grassley talked about cut $465 billion out of Medicare and starting a new entitlement program, a new entitlement program at the time that this Nation has just passed or just incurred the largest single deficit in the history of the American Republic, $1.4 trillion. Next year, we are going to add $1 trillion, according to the Congressional Budget Office—not me.

Is this smart? To have a program that people have depended on, that we have a moral compact to support—to have the support of those savings paid into this plan for 40 years, now taking money out of that to create a new program? It is, in fact, in quite a number of areas, going to cost far more than is being suggested by the people who are proposing it. We are going to dig into this and try to analyze it with more clarity, but the truth is, the numbers just do not add up. They will not work. We just ought not to be establishing a new entitlement program of massive proportions in a way where we really have little concept of how it is going to play out at a time of the largest deficits this Nation has ever had. If deficits, that according to our own Congressional Budget Office, will double the national debt in 5 years and triple it to $17 trillion in 10 years.

It is an unsustainable course, and one of the first things we have to do is watch how we spend our money. I talked to an individual today. He said: It is like your house is in serious need of repair. You really don’t have the money to fix it. You finally decide you have to borrow money to fix the house, and instead you borrow money and add a wing onto the house.

We need to close the Medicare house we have. We need to make sure we honor our commitment to Medicare recipients. They have already paid. That is the important point to remember. They have already paid their working life under a compact and a commitment that nothing would be in a fund that would be available. We ought not to be taking it away.

I urge colleagues to think about this. This is perhaps the most significant fatal flaw in the legislation. It just doesn’t add up. There are others, but this one, to me, is the most dramatic, the most pernicious, the one that is most untrue. We simply need to slow down, ask ourselves how we can make our health care system better, how we can do it without breaking the bank. Aren’t there some things we can do to improve health care without a huge cost? Yes, there are. Let’s start with every single one of them we can agree on. If we do that, I think we could make a lot of progress.

Who knows, if this economy turns around—and we all hope it will—we would be in a better footing to consider a new benefit in the future.

I thank the floor. I think we could make a lot of progress.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak up to 10 minutes each.

THANKS. SIR. Without objection, it is so ordered.

REMEMBERING MAJOR GENERAL CHARLES BEACH, JR.

Mr. McCONNELL. Mr. President, I am here today to remember the life of a dear friend, MG Charles Beach Jr., of Beattyville, KY. General Beach passed away this past Veterans Day, at the age of 90. He was a genuine servant to his home community, the Commonwealth of Kentucky. While General Beach will be greatly missed, the contributions that he has made to Kentucky, and the sacrifices that he has made for this Nation, will surely live on as his legacy.

Charles Beach knew from a young age that he wanted to serve his country, and in 1940, he graduated from the Virginia Military Institute in Lexington, VA. Shortly after graduation, he completed his basic training and began his active service. While in Italy in 1944, Charles became severely wounded during battle. He spent the next 8 months recovering in a military hospital and was awarded the Purple Heart.

Charles Beach joined the Army Reserve after he was released from active duty. After a short time in the Reserves, Beach was recommissioned into the U.S. Army, this time with the rank of major. In 1976, he was promoted to major general after becoming the 18th Commander of the 100th Division, where he commanded the Kentucky Army Reserve Training Division.

General Beach’s contributions extended beyond his military service; he was an active member of his beloved hometown of Beattyville. The general served his community through many organizations including, as chairman of People Exchange Bank and Insurance, president of the Beattyville/Lee County Chamber of Commerce, president of the Lee County Phoenix Retirement Village, and cofounder of a scholarship program to aid eastern Kentucky students wanting to pursue careers in medicine.
This scholarship has increased the number of doctors in eastern Kentucky.

For his service to the community, General Beach received several awards, including the Kentucky Chamber of Commerce Volunteer of the Year, and the Community Bankers of Kentucky Outstanding Community Banker of the Year awards. The Beattyville/Lee County Chamber of Commerce recognized General Beach for his 58 consecutive years as president. And, Beattyville Mayor Joseph Beach described General Beach as “a true gentleman and a hero of this community. It is appropriate that his passing was on Veterans Day. He was a true patriot.”

The positive impact that General Beach has made on Kentucky and this Nation has certainly not ended with his passing. His legacy will continue to live on through the individuals and the communities he so lovingly helped lead. Known nationally for his leadership and service to our country, I know all Kentuckians join me in grieving the loss of Charles Beach.

HONORING OUR ARMED FORCES

CORPORAL ANTHONY CARRASCO, JR.

Mr. UDALL of New Mexico. Mr. President, I rise today to honor a brave son of Anthony Army CPL Anthony Carrasco Jr. was killed November 4 after being hit by sniper fire while serving his country in Iraq. He was 25 years old.

Carrasco—or “Tony” as he was called by family and friends—was a husband and father and son. He and his wife Johana are expecting a child. And he had two small step-children who adored him.

Tony served as truck commander for armored vehicles. It was his job to direct his vehicle down streets infested with roadside bombs and targeted by insurgents attacking from the shadows of buildings. Tony understood the danger. He accepted the risk. And he died doing what he loved, serving a country he loved.

His fellow soldiers described Tony as an optimist. His platoon sergeant, Timmy Brown, put it best: Tony “saw the good in everything. He was a soldier who never, ever complained.” Sergeant Brown called Tony “the best soldier I ever had.”

As Senators or as citizens, we cannot fully experience the sadness that Tony’s family and friends are feeling. But when a soldier dies, the Nation as a whole feels the loss. We are linked to Corporal Carrasco by the ties that bind a grateful Nation to its faithful servant. His loss is ours.

Please join me in honoring Anthony Carrasco, and extending our sympathies to Johana, his father Antonio, his mother Juana, and the rest of the Carrasco family.

SPECIALIST JOSEPH GALLEGOS

Mr. President, I want to acknowledge the recent passing of brave New Mexican Specialist Joseph Gallegos, a specialist with the New Mexico Army National Guard, died of a heart attack while serving in Iraq.

While his death was not due to injuries suffered in combat, that fact does not lessen his loss.

Specialist Gallegos was 39 years old. He served with the Guard as a light wheel vehicle mechanic. When not serving his country, he worked for the Forest Service. He was a firefighter, an ambulance driver and a policeman.

Specialist Gallegos gravitated toward work that allowed him to help his fellow citizens. While working for the Forest Service, he even saved a life—spotting a burning truck one day, he saw a man inside and pulled him to safety.

As Specialist Gallegos’ brother, Donald, said: “He was always taking different jobs, but they always put him in the service of others.”

Today, I ask you to join me in thanking Specialist Gallegos’ family for his service, and for his sacrifice.

TRIBUTE TO DR. GARETH PARRY

Mr. KAUFMAN. Mr. President, I wish to honor the service of a great Federal employee.

Human ingenuity is boundless. This is especially true in America, which has always been driven by an entrepreneurial spirit and a belief that nothing is impossible.

From Whitney’s cotton gin to the first elevator, from the electric telegraph to the refrigerated rail car, our forbearers used their ingenuity to help build a nation. Such invention and perseverance closed the western frontier in the nineteenth century. In the century that followed, Americans continued to be pioneers on that frontier which has no end—the frontier of science.

Sixty-seven years ago this week, a team of American physicists led by Enrico Fermi conducted a critical experiment. On a cold winter’s afternoon, they huddled under the stands of the old football stadium at the University of Chicago. Using graphite blocks, wooden rods, and uranium pellets, they initiated the first-ever controlled nuclear reaction.

That experiment, called “Chicag Pile One,” marked the beginning of the nuclear age.

Today all Americans know that the discovery of nuclear power was a mixed blessing. With it came the potential for destruction of our fellow citizens. And it brought a generation of nuclear weapons for the last 20 years. Today, I would like to speak for a few minutes about the critical importance of an offensive strategic arms reduction, and why we must establish a follow-on treaty to START.

In September, President Obama proposed a resolution to the United Nations Security Council to eliminate nuclear weapons, ban production of the fissile material, outlaw nuclear tests,
and safeguard existing weapons stockpiles. World leaders approved the resolution, joining with the President's previous statements that "America seeks a world with no nuclear weapons." This is not a vision of unilateral disarmament, but a vision for a nuclear-free world.

In the past few years, we have seen a rise in clandestine nuclear programs developed by rogue states, including those which have successfully acquired a nuclear arsenal. This growing threat—primarily from North Korea and Iran—underscore the value of international strategic arms treaties. These are global challenges which require global solutions and a multilateral approach. The best way to confront nuclear proliferation is unity of the international community, and I am pleased that one of the greatest successes of President Obama's policy of engagement with Iran has been a growing convergence of views identifying Iran's nuclear program as a threat not just to one region but to the world.

While multilateralism is the best way to effectively reduce the threat posed by nuclear weapons, we must look to successful bilateral agreements as a model, including START. This treaty laid the groundwork for a common understanding between the United States and Russia regarding nuclear weapons, and truly symbolized the end of the Cold War. It allowed us to talk about previously taboo subjects, such as the Triad and intrusive verification, and develop a shared language of expertise and evaluation that reduced our nuclear arsenals. More importantly, it provided a process of arbitration that avoids confrontation, establishes legal mechanisms to forever avoid a nuclear war.

The stability START provided allowed both the United States and Russia to reduce our nuclear stockpiles and engage in negotiations about curbing proliferation worldwide. It also built great confidence in the other as a partner. Since its inception, START has served as an enabler of global non-proliferation efforts. Now this critical treaty is set to expire, and it is time to move forward with a follow-on which reflects the requirements of the 21st century, and allows the United States and Russia to continue this valuable partnership in nonproliferation together.

This is why I am a cosponsor of legislation which provides a legal basis for extending the START verification regime, and I strongly support the work of the Obama administration—under the leadership of Assistant Secretary of State for Verification and Compliance Rose Gottemoeller—to negotiate a follow-on. We now have a chance to allow Americans to place consideration of the new treaty at the top of the agenda when it is submitted, so the United States can continue to pave the way toward safer and more secure world.

SOMALIA

Mr. FEINGOLD. Mr. President, just over 6 months ago, this Congress was abuzz with concern about piracy off Somalia's coast. Following the attack on a U.S.-flagged ship, the MV Maersk Alabama, and capture of CPT Richard Phillips, no less than five congressional committees held hearings on this topic.

There was intense discussion about the steps that should be taken by our ships and our Navy to help prevent these attacks. And the State Department subsequently announced several steps it would take to combat piracy, including working with the International Contact Group on Piracy to expand the multinational naval operation to patrol the waters off Somalia's coast. The United States, China, India, Russia, the European Union, and many other nations have deployed naval forces to the region that are working together to combat piracy—a remarkable show of international cooperation.

Those naval efforts have had some success. Reports indicate that attacks have declined considerably over the summer months with the monsoon season, attacks appear to be on the rise again. The International Maritime Bureau reports that 38 ships have been attacked and 10 hijacked in just 2 months. This includes the Maersk Alabama, which was attacked again on November 18. It also includes a supertanker carrying $20 million in crude oil that was seized this week en route from Saudi Arabia to New Orleans. The UN Secretary General warned in July that "as a result of the military presence in the region, pirates have employed more daring operational tactics, operating further seawards, toward the Seychelles, and using more sophisticated weaponry against our attacks" to bear out the Secretary General's concern. Even more disconcerting, Jeffrey Gettleman of the New York Times reported this week that more Somalis were assassinated. We need to help with the regions to maintain and strengthen their relative stability. And in the case of Somaliland, there is a unique tradition of democratic rule that we ought to encourage, although I am disappointed that Somaliland's elections have been repeatedly postponed.

At the same time, more engagement with northern Somalia does not mean we should neglect the rest of the country. The raging conflict and resulting humanitarian crisis in central and southern Somalia is of our concern. Just yesterday, a suicide bomber attacked a graduation ceremony in Mogadishu, killing at least 10 people, including 3 Ministers of the Transitional Federal Government. This demonstrates the fragility of the TFG, which continues to face a strengthened al Shebaab and allied militias. Over the weekend, al Shebaab, a group with links to al-Qaeda, seized another major town in southern Somalia. In addition to these security challenges, the TFG has wrestled with governance, capable law enforcement, and economic opportunity in Somalia. As leading Somalia expert Dr. Ken Menkhaus has said, it will be impossible to end the piracy when "the risks are so low, rewards so high and alter- natives so bleak in desperate Somalia.

Changing that equation requires real change on land.

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Mr. BOXER. Mr. President, I take this opportunity to honor the life of Tom Graff. Tom was one of the founders of the environmental movement. Mr. Graff passed away on November 12, 2009, after a long battle with cancer. He was 65.

Born in Honduras in January 1944, Tom Graff was the son of German Jewish refugees. He spent his childhood in Syracuse, NY, attending Phillips Exeter Academy. He later graduated from Harvard University, Harvard Law School, and the London College of Economics. After Tom clerked for Federal Judge Carl McGowan in Washington, DC, and was a legislative assistant to New York Mayor John Lindsay. In 1970, he moved to California to work for Howard, Prim, Smith, Rice, and Brown, a law firm based in San Francisco.

In 1971, Tom founded the California office of the Environmental Defense Fund. From then until 2008 when he retired, Tom served as Environmental Defense Fund’s regional director. For more than 37 years, Tom worked tirelessly and passionately as an advocate for the environment. He established a new form of environmental activism based on the idea that economics could, and should, play a significant role in environmental policy-making. Tom believed that paying attention to how economic incentives influence business and personal behavior was critical to bringing about environmental improvements.

Although he was involved with a number of environmental issues, it was Tom’s significant contributions to water policy that left an indelible mark in California. From the American River to the Sacramento-San Joaquin Delta, Tom strove to ensure that water was distributed appropriately, and that the environment got its fair share. Working together with Senator Bill Bradley of New Jersey and Congressman Gonzo Miller of Martinez, Tom was a guiding force behind the Central Valley Project Improvement Act of 1991, a milestone in the environmental movement to protect the delta. He helped craft the historic proposal to use water markets and public subsidies that ultimately resolved the controversy around Mono Lake. He also did battle with the East Bay Municipal Utility District when it sought a second source of water from the American River, known for its abundant fall salmon run. Concerned for the health of the river, the Environmental Defense Fund filed suit against EBMUD. Seventeen years later, a landmark decision designated a baseline environmental flow need for the American River that stands to this day as a benchmark in river policy.

Throughout his career, Tom’s commitment to conservation and the benefits it brought was evident in the work he did every day. His lifetime of contributions and his stewardship of the environment will not soon be forgotten.

Tom is survived by his wife Sharona Barzilay; his three children Samantha, Benjamin, and Rebecca; and two grandsons. I extend my deepest sympathy to his family.

Tom was a true pioneer and advocate for a healthy and sustainable environment, working tirelessly to provide new approaches for managing natural resources. His efforts will continue to shape California’s water policies for generations to come.●

REMEMBERING MITCH DEMIENTIEFF

Ms. MURKOWSKI. Mr. President, last April I spoke about the loss of Buddy Brown, a leader of the Athabascan people of interior Alaska, who served as president of the Tanana Chiefs Conference, Inc. Buddy died at the age of 39.

Today it is my sad duty to report the passing of another Athabascan leader and former president of the Tanana Chiefs Conference, Mitch Demientieff of Nenana. Mitch died unexpectedly on Tuesday, December 1, at the age of 57. Like Buddy, he left us too soon. He accomplished so much in a short time and was taken from us when he had so much more to give.

Mitch was first elected president of the Tanana Chiefs Conference in 1973 at the age of 20. He was elected to serve in that role again in 1987. Today, the Tanana Chiefs Conference is an economic powerhouse in interior Alaska employing hundreds of people and administering a wide range of Bureau of Indian Affairs and Indian Health Service programs on behalf of some 10,000 Native people in a territory that extends 235,000 square miles. TCC is looked upon as a national pioneer in Indian self determination and that is in large measure due to the leadership initiatives of Mitch Demientieff. Under Mitch’s leadership, TCC created a regionwide health care delivery system which is today anchored by the Chief Andrew Isaac Health Center in Fairbanks. Mitch had the good fortune of serving as president of TCC in the run-up to passage of the Indian Self Determination and Educational Assistance Act of 1975. He positioned TCC as an early adapter of this powerful tool through which Native people rely upon their tribes, rather than the Federal Government, to deliver Federal Indian programs and services. TCC has used these authorities wisely to improve the quality of services to the people of interior Alaska and provide life changing career opportunities to Native people from remote Fairbanks area communities throughout its region. It also began to administer housing, lands management, tribal government assistance, public safety, education and employment and natural resources programs. One of the characteristics that distinguish Alaska’s Native people is the continued reliance on traditional ways of living in our villages. Subsistence, the use of the Earth’s resources for cultural and emotional sustenance, as well as food, is the way of life in interior Alaska.

Mitch Demientieff, even while running a multi-million dollar tribal enterprise, never forgot that subsistence...
is fundamental to the survival of his Native people. Whatever else might have competed for his attention subsidence came first.

In 1995, when Interior Secretary Bruce Babbitt assumed responsibility for the subsistence protection of the Alaska National Interest Lands Conservation Act, he turned to Mitch as his man on the ground. Mitch chaired the Federal Subsistence Board from 1995 until 2006 protecting the subsistence interests of rural Alaskans throughout the State.

Nor did Mitch ignore the needs of his own Native village of Nenana, which sits about 60 miles south of Fairbanks. Mitch chaired both the Nenana tribe and the village Native Corporation.

I extend my condolences to Kathleen and the entire Demientieff family, a grand Alaskan family with a tradition of leadership, and all of our Native people on the loss of this Chief whose contributions were greatly respected throughout Alaska.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MEASURES DISCHARGED

The following bill was discharged from the Committee on the Homeland Security and Governmental Affairs by unanimous consent, and referred as indicated:

S. 2139. A bill to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia for the establishment of a National Women's History Museum; to the Committee on Environment and Public Works.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-3881. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; Boeing Model 767 Airplanes’’ ((RIN2120-AA64)(Docket No. FAA–2009–2623)) as received during adjournment of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3882. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; Boeing Model 777 Airplanes’’ ((RIN2120-AA64)(Docket No. FAA–2009–2622)) as received during adjournment of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3883. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; Aviation Turbomeca Model TBM 700 Airplanes’’ ((RIN2120-AA64)(Docket No. FAA–2009–0557)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3884. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; Bombardier Model CL–600–1A11 (CL–600), CL–600–2B16, DeHavilland DHC–8–201, DHC–8–202, DHC–8–301, DHC–8–311, and DHC–8–315 Airplanes’’ ((RIN2120–AA64)(Docket No. FAA–2009–1070)) as received during adjournment of the Office in the Senate of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.


EC-3886. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; Bombardier Model DRC–8–102, DRC–8–103, DRC–8–106, DHC–8–600, DHC–8–831, and DHC–8–315 Airplanes’’ ((RIN2120–AA64)(Docket No. FAA–2009–1072)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.


EC-3888. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Authority for New Orleaneous, LA’’ ((RIN2120–AA66)(Docket No. FAA–2009–0405)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3889. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Modification of the New York, NY Class E Airspace Area; and Establishment of the New York Class B Airspace Area; and Establishment of the New York Class D and Class E Airspace’’ ((RIN2120–AA66)(Docket No. FAA–2009–0405)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3890. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Amendment of Class D and Class E airspace, Mankato, MN’’ ((RIN2120–AA66)(Docket No. FAA–2009–0677)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3891. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Adjustment of the Monetary Threshold for Agreements and Appointment of Agents’’ ((RIN2120–AA66)(Docket No. FAA–2009–0837)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3892. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Airworthiness Directives; General Electric Aircraft Engines’’ ((RIN2120–AA64)(Docket No. FAA–2009–0869)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3893. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Standard Instrument Approach Procedures; Amends. No. 3346’’ ((RIN2120–AA65)(Docket No. FAA–2009–0870)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3894. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Amendment of Class D and Class E Airspace; New Orleans NAS, LA’’ ((RIN2120–AA66)(Docket No. FAA–2009–0405)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3895. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Amendment of Class D and Class E Airspace; East River Exclusion Special Flight Rules Area’’ ((RIN2120–AA66)(Docket No. FAA–2009–0837)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3896. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Agency Agreements and Appointment of Agents’’ ((RIN2120–AA63)(Docket No. FAA–2009–0970)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3897. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ‘‘Adjustment of the Monetary Threshold for Agreements and Appointment of Agents’’ ((RIN2120–AA63)(Docket No. FAA–2009–0970)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.
Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3837. A communication from the Deputy Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “ Wassenaar Agreement 2008 Plenary Agreement Implementation: Categories 1, 2, 3, 4, 5 Parts I and II, 6, 7, 8 and 9 of the Commerce Control List.” (EIN3964-AE58) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3838. A communication from the Secretary of the Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled “Guides Concerning the Use of Endorsements and Testimonials in Advertising.” (CFR 16, Parts 201 and 202) as received in the Office of the President of the Senate on November 30, 2009; to the Committee on Commerce, Science, and Transportation.

INTRODUCTION OF BILLS AND joint resolutions

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. KOHL (for himself and Ms. SNOWE):

S. 2836. A bill to improve the Operating Fund for public housing of the Department of Housing and Urban Development, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. LINCOLN:

S. 2837. A bill to part B of title IV of the Social Security Act to examine and improve the civil welfare force, and for other purposes; to the Committee on Finance.

By Mr. BENNET:

S. 2838. A bill to give critical access hospitals priority in receiving grants to implement health information technology, to expand participation in the drug pricing agreement program under section 340B of the Public Health Service Act, to provide for a study and report on pharmacy dispensing fees under Medicaid, to provide for continuing funding for operation of State offices of rural health and public health purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. KLOBUCHAR (for herself, Mr. GRAHAM, and Mr. FRANKEN):

S. 2839. A bill to amend the Torture Victims Relief Act of 1998 to authorize appropriations to provide assistance for domestic and foreign programs and centers for treatment, prevention of torture, and for other purposes; to the Committee on Foreign Relations.

By Mr. MENENDEZ:

S. 2840. A bill to amend title III of the Public Health Service Act to provide for the establishment and implementation of concussion management guidelines with respect to school-aged children, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MCCONNELL (for himself, Mr. RIEDE, Mr. NELSON of Florida, Mr. LEHMIEUX, Mr. AKARA, Mr. ALEXANDER, Mr. MARLASSO, Mr. BAUCUS, Mr. BAYH, Mr. BEGICH, Mr. BENNET, Mr. BENNETT, Mr. BINGMAN, Mr. BOND, Mrs. BICKER, Mr. BROWN, Mr. BROWNEBACK, Mr. BUNDING, Mr. BURR, Mr. BURDUS, Mr. BYRD, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CARR, Mr. CHAMBER, Mr. CONROY, Mr. COCHRAN, Mr. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mr. DORAN, Mr. DURBIN, Mr. ENZI, Mr. ENZI, Mr. FREROLIO, Mrs. FINNSTEIN, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREED, Mrs. HAGAN, Mr. HARKIN, Mr. HATCH, Mrs. HITCHISON, Mr. INSFHOPE, Mr. INGUYE, Mr. ISAKSON, Mr. JOHNSON, Mr. JOHNSON, Mr. KAMPMAN, Mr. KIRK, Ms. KLOBUCHAR, Mr. KORIL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LUGAR, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Mr. MERKLEY, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Ms. NELSON of Nebraska, Mr. PSEYOR, Mr. REED, Mr. RISCH, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mrs. SHARRER, Ms. SNOWE, Mr. SPLECHTER, Ms. STABENOW, Mr. TESTER, Mr. THUNE, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. VITTER, Mr. VONNOVICE, Mr. WARNE, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN):

S. Res. 370. A resolution relative to the death of Paula F. Hawkins, former United States Senator for the State of Florida; considered and agreed to.

ADDITIONAL COSPONSORS

S. 624. At the request of Mr. DURBIN, the names of the Senator from Kansas (Mr. ROBERTS) and the Senator from Delaware (Mr. KAUFMAN) were added as cosponsors of S. 624, a bill to provide 100,000,000 people with first-time access to safe drinking water and sanitation on a sustainable basis by 2015 by improving the capacity of the United States Government to fully implement the Safe Drinking Water Act to increase the number of physicians who practice in underserved rural communities.

S. 631. At the request of Mr. DURBIN, the name of the Senator from Utah (Mr. BENTNETT) was added as a cosponsor of S. 631, a bill to require the Secretary of the Treasury to mint coins in commemoration of the National Future Farmers of America Organization and the 85th anniversary of the founding of the National Future Farmers of America Organization.

S. 643. At the request of Mr. KOHL, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 643, a bill to prevent later discipline and improve the health and well-being of maltreated infants and toddlers through the development of local Court Teams for Maltreated Infants and Toddlers and the creation of a National Court Teams Resource Center to assist such Court Teams, and for other purposes.

S. 653. At the request of Mr. DURBIN, the name of the Senator from Utah (Mr. BENTNETT) was added as a cosponsor of S. 653, a bill to require the Secretary of the Treasury to mint coins in commemoration of the bicentennial of the Star-Spangled Banner, and for other purposes.

S. 655. At the request of Mr. UDALL of Colorado, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 655, a bill to amend title VII of the Public Health Service Act to increase the number of physicians who practice in underserved rural communities.
At the request of Mr. Burr, the name of the Senator from Illinois (Mr. Durbin) was added as a cosponsor of S. 1629, a bill to authorize the Secretary of the Interior to conduct a special resource study of the archelogical site and surrounding land of the New Philadelphia town site in the state of Illinois, and for other purposes.

S. 1688

At the request of Mr. Bennett, the name of the Senator from New Hampshire (Mr. Shaheen) was added as a cosponsor of S. 1688, a bill to amend title 38, United States Code, to provide for the inclusion of certain active duty service in the reserve components as qualifying service for purposes of Post-9/11 Educational Assistance Program, and for other purposes.

S. 1695

At the request of Ms. Landrieu, the name of the Senator from Louisiana (Mr. Vitter) was added as a cosponsor of S. 1695, a bill to authorize the Secretary of the Interior to provide financial assistance to the State of Louisiana for a pilot program to develop measures to eradicate or control feral swine and to assess and restore wetlands damaged by feral swine.

S. 2097

At the request of Mr. Thune, the names of the Senator from Mississippi (Mr. Wicker) and the Senator from Hawaii (Mr. Inouye) were added as cosponsors of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2370

At the request of Mr. Brown, the names of the Senator from West Virginia (Mr. Bye), the Senator from Massachusetts (Mr. Kirk) and the Senator from Iowa (Mr. Harkin) were added as cosponsors of S. 2370, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2781

At the request of Ms. Mikulski, the names of the Senator from Washington (Mrs. Murray) and the Senator from New Hampshire (Mrs. Shaheen) were added as cosponsors of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2871

At the request of Mrs. McCaskill, the name of the Senator from Montana (Mr. Tester) was added as a cosponsor of S. 2871, a bill to provide personal jurisdiction in causes of action against contractors of the United States performing contracts abroad with respect to members of the Armed Forces, civilian employees of the United States, and United States citizen employees of companies performing work for the United States in connection with contract activities, and for other purposes.

S. 2796

At the request of Mr. Enzi, the name of the Senator from Texas (Mrs. Hutchison) was added as a cosponsor of S. 2796, a bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes.

S. 2831

At the request of Mr. Reed, the name of the Senator from Michigan (Ms. Stabenow) was added as a cosponsor of S. 2831, a bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes.

S. 2853

At the request of Mr. KERRY, the names of the Senator from California (Mrs. Boxer) and the Senator from New Hampshire (Mrs. Shaheen) were added as cosponsors of S. 2853, a bill to reduce global warming pollution through international climate finance, investment, and for other purposes.

AMENDMENT NO. 2789

At the request of Mr. Brown, his name was added as a cosponsor of amendment No. 2789 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2798

At the request of Mr. Frank, his name was added as a cosponsor of amendment No. 2798 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

At the request of Mr. Johnson, his name was added as a cosponsor of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2869

At the request of Mr. Nelson of Florida, the name of the Senator from Rhode Island (Mr. Whitehouse) was added as a cosponsor of amendment No. 2869 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2871

At the request of Mr. Brown, the names of the Senator from Minnesota (Mr. Franken), the Senator from Rhode Island (Mr. Whitehouse), the Senator from Vermont (Mr. Sanders) and the Senator from Pennsylvania (Mr. Specter) were added as cosponsors of amendment No. 2871 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KOHL (for himself and Ms. Snowe):

S. 2836. A bill to improve the Operating Fund for public housing of the Department of Housing and Urban Development, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. KOHL. Mr. President, I rise today to discuss the Asset Management
Byrd, Ms. Cantwell, Mr. Cardin, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2886. Mr. Feingold (for himself, Ms. Klobuchar, Mr. Kohl, and Mr. Wyden) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2887. Mr. Cornyn submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2888. Mr. Coburn submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2889. Mr. Carper submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2900. Mr. Reid submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2901. Mr. Carper submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2902. Mr. Carper submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2903. Mr. Casey (for himself and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2904. Mr. Brown (for himself, Mr. Schumer, and Mr. Sanders) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2905. Mr. Brown (for himself, Mr. Schumer, and Mr. Sanders) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2906. Mr. Udall of New Mexico submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2907. Mr. Udall of New Mexico submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2908. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2909. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2910. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2911. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2912. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2913. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2914. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.

SA 2915. Mr. Lieberman (for himself, Ms. Collins, and Mr. Specter) submitted an amendment intended to be proposed to amendment S. 2768 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill S. 3590, supra; which was ordered to lie on the table.
SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2901. Mr. STEBENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2902. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2903. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2905. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2915. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2918. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2920. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2921. Ms. STABENOW (for herself and Mrs. MCCASKILL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2922. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2923. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BINGAMAN, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TSERKEZ, and Mr. INOUE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2924. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BINGAMAN, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TSERKEZ, and Mr. INOUE) submitted an amendment to the Internal Revenue Code of 1986 to modify the first-time homeowners credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In title XI of such division, insert the following:

SEC. 10001. DELAYED IMPLEMENTATION.
Notwithstanding any other provision of this Act or the amendments made by this Act, such provisions or amendments shall not take effect before the date that the Report of Trustees of the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1396) submits an annual report to Congress under subsection (c) of section 1817 that includes a statement that such Trust Fund is projected to be solvent through 2037.

SA 2981. Mr. JOHANNSS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986, to modify the first-time homeowners credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. PROTECTING MEDICARE BENEFICIARIES’ ACCESS TO HOME HEALTH SERVICES.
Notwithstanding the provisions of, and amendments made by, sections 3131 and 3132, such provisions and amendments are repealed.

SA 2983. Ms. STABENOW (for herself, Mr. BINGAMAN, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986, to modify the first-time homeowners credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In subtitle C of title IV, insert the following:

SEC. 4208. CENTERS OF EXCELLENCE FOR DEPRESSION.
(a) Short Title.—This section may be cited as the ‘‘Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009’’ or the ‘‘ENHANCED Act of 2009’’.
SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term ‘depressive disorder’ means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

(b) GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as the ‘coordinating center’), which shall engage in activities related to the treatment of depressive disorders.

(2) ALLOCATION OF AWARDS.—If the funds authorized under this section are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 centers of excellence may be established; and

(B) not later than September 30, 2016, not more than 30 centers of excellence may be established.

(c) GRANT PERIOD.—

(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

(B) RENEWAL.—A grant awarded under subsection (a) may be renewed, on a competitive basis, for an additional 2-year period, if the Secretary determines that the grantee has met the criteria described in subparagraph (A).

(d) ELIGIBLE ENTITIES.—

(A) GRANT APPLICATION—To be eligible to receive a grant under this section, an entity shall—

(i) be an institution of higher education or a public or private nonprofit research institution; and

(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

(i) evidence that such entity—

(I) provides, or is capable of coordinating with other entities to provide, comprehensive mental and behavioral health services with a focus on mental health services and sub specialty expertise for depressive disorders;

(II) collaborates with—

(aa) other mental health professionals about mental health; and

(b) community organizations; and

(cc) other members of the network; and

(II) is capable of training health professionals about mental health; and

(ii) such other information, as the Secretary may require.

(e) USE OF FUNDS.—Grant funds awarded under this section shall be used for the establishment and ongoing activities of the recipient of such funds.

(f) DUTIES.—The coordinating center shall—

(i) develop, administer, and coordinate the network of centers of excellence under this section;

(ii) coordinate and the national database described in subsection (d);

(iii) develop a strategic plan to disseminate the findings and activities of the centers of excellence through such means as the Secretary determines to be appropriate, and submit such plan to the Secretary for approval; and

(iv) establish a common network infrastructure to advance services provided by the centers of excellence and demonstrate effectiveness in fostering a collaborative community among such centers for sharing knowledge and skills.

(g) NATIONAL DATABASE.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contracts or subcontracts with other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(h) ACTIVITIES OF THE CENTERS OF EXCELLENCE.—Each center of excellence shall carry out the following activities:

(I) GENERAL ACTIVITIES.—Each center of excellence shall—

(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development of evidence-based interventions;

(B) expand a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop the research agenda, and conduct the research findings of such center, and to provide support in the implementation of evidence-based practices;

(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders; and

(D) facilitate the dissemination and communication of research findings and depressive disorder-related information from the institutions of higher education to the public; and

(E) educate policy makers, employers, community leaders, and the general public about depressive disorders to reduce stigma and raise awareness of available treatments for such disorders.

(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, AND DIAGNOSTIC PROTOCOLS.—Each center of excellence shall collaborate with other centers of excellence in the network to—

(A) develop and implement treatment standards, clinical guidelines, and protocols to improve the accuracy and timeliness of diagnosis of depressive disorders; and

(B) develop and implement treatment standards that emphasize early intervention and treatment for, primary prevention and the prevention of recurrences of, and recovery from, depressive disorders.

(3) COORDINATION AND INTEGRATION OF PHYSICAL, MENTAL, AND SOCIAL CARE.—Each center of excellence shall—

(A) incorporate principles of chronic care coordination and integration of services that address physical, mental, and social conditions in the treatment of depressive disorders; and

(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders.

(C) identify how treatment for depression interacts with such co-occurring illnesses to improve overall health outcomes.

(D) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

(E) use electronic health records and tele-health technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

(4) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS OF EXCELLENCE AND COMMUNITY-BASED ORGANIZATIONS.—Each center of excellence shall—

(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

(B) expand multidisciplinary, translational, and patient-oriented research and development by fostering such collaborations; and

(C) coordinate with accredited academic programs to provide ongoing opportunities, including clinical and in-kind services, for the professional and continuing education of mental health providers.

(D) NATIONAL DATABASE.—
PARTY REVIEW.—

(A) DATA.—Each center of excellence shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

(i) the prevalence and incidence of depressive disorders;

(ii) the health and social outcomes of individuals with depressive disorders;

(iii) the effectiveness of interventions designed, tested, and evaluated;

(iv) the progress in the prevention of, and recovery from, depressive disorders; and

(v) the economic impact of the activities of such center.

(B) FINANCIAL INFORMATION.—Each center of excellence shall provide to the coordinating center appropriately summarized financial information to enable the coordinating center to rate the performance of such center.

(C) SENSE OF THE SENATE.—It is the sense of the Senate that the knowledge and research developed by the centers for depression established under section 520B of the Public Health Service Act should be disseminated broadly within the medical community and the Federal Government, particularly to agencies with an interest in mental health, including other agencies within the Department of Health and Human Services and the Departments of Justice, Defense, Labor, and Veterans Affairs.

SA 2884. Ms. STABENOW (for herself, Mr. KERRY, Mrs. BOXER, Ms. LOUGHBAN, Mr. BACH, Mr. LUTEN, Mr. BURTON, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII insert the following:

Subtitle C—Heart Disease Education, Analysis Research, and Treatment for Women

SEC. 7201. SHORT TITLE.

This subtitle may be cited as the "Heart Disease Education, Analysis Research, and Treatment for Women Act" or the "HEART Act for Women".

SEC. 7202. REPORTING OF DATA IN APPLICATIONS FOR DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES.

(a) DRUGS.—

(1) NEW DRUG APPLICATIONS.—Section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended—

(A) in paragraph (1), in the second sentence—

(i) by striking "drug, and (G)");

(ii) by inserting before the period the following:

"(H) the information required under section 505(b) of such Act.");

(b) BY REPORTING OF DATA IN APPLICATIONS FOR DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES.

(1) P REMARKET APPROVAL .—Section 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) is amended by adding at the end the following paragraph:

"(7) To the extent consistent with the regulation of devices, the provisions of section 515 relating to clinical data submission apply with respect to an application for premarket approval of a device under subsection (c) of this section to the same extent and in the same manner as such provisions apply with respect to an application for premarket approval of a drug under section 505(b) of such Act.");

(c) DEVICES .—

(1) PREMARKET APPROVAL.—Section 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) is amended—

(A) in subsection (c)(1)—

(i) by moving the margin 2 ems to the left; and

(ii) by striking "and" after the semicolon at the end;

(B) by redesignating paragraph (H) as paragraph (J) and;

(C) by inserting after paragraph (G) the following subparagraph:

"(H) the information required under subsection (d); and"

(B) in subsection (d), by adding at the end the following paragraph:

"(7) To the extent consistent with the regulation of devices, the provisions of section 515 relating to clinical data submission apply with respect to an application for premarket approval of a device under subsection (c) of this section to the same extent and in the same manner as such provisions apply with respect to an application for premarket approval of a drug under section 505(b) of such Act.");

(2) INVESTIGATIONAL DEVICES.—Section 520(g)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360g) is amended by adding at the end the following subpart:

"(D) To the extent consistent with the regulation of devices, the provisions of section 515 relating to clinical data submission apply with respect to an application for an exemption pursuant to subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to an application for an exemption under section 505(i)."
SA 2887. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title B of title IV, insert the following:

SEC. 410H. REAUTHORIZATION OF TELEHEALTH PROGRAMS.

(a) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—Section 1005 of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 254c-17(b)) is amended by striking “2002 through 2006” and inserting “2011 through 2015”.

(b) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 1005(a) of the Public Health Service Act (42 U.S.C. 254c-16(e)) is amended by striking “2003 through 2006” and inserting “2011 through 2015”.

SA 2886. Mr. FEINGOLD (for himself, Ms. KLOBUCHAR, Mr. KOHL, and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 751, between lines 2 and 3, insert the following:

SEC. 410B. IMPROVEMENTS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)(1), by inserting “or critical access hospitals” before the period at the end; and

(2) in paragraph (2), by adding at the end the following new subparagraph:

“The ACO shall take into account the special needs of hospitals located in rural areas.”;

(b) GAO STUDY AND REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall conduct a study containing the results of the study conducted under paragraph (1), together with respect to the proposed legislation and administrative action as the Comptroller General determines appropriate.

(b) RULES OF CONSTRUCTION.—This subtitle shall take into account the quality of and access to care for women and any disparities between treatments, and shall provide that any benchmark established by the Secretary of Health and Human Services to ensure regulations under the Federal Food, Drug, and Cosmetic Act that are not otherwise referenced in this subtitle or the amendments made by this subtitle.

SEC. 3022A. IMPROVEMENTS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)(1), by inserting “or critical access hospitals” before the period at the end; and

(2) in paragraph (2), by adding at the end the following new subparagraph:

“The ACO shall take into account the special needs of hospitals located in rural areas.”;

(b) GAO STUDY AND REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall conduct a study containing the results of the study conducted under paragraph (1), together with respect to the proposed legislation and administrative action as the Comptroller General determines appropriate.

(b) RULES OF CONSTRUCTION.—This subtitle shall take into account the quality of and access to care for women and any disparities between treatments, and shall provide that any benchmark established by the Secretary of Health and Human Services to ensure regulations under the Federal Food, Drug, and Cosmetic Act that are not otherwise referenced in this subtitle or the amendments made by this subtitle.

SEC. 3022A. IMPROVEMENTS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)(1), by inserting “or critical access hospitals” before the period at the end; and

(2) in paragraph (2), by adding at the end the following new subparagraph:

“The ACO shall take into account the special needs of hospitals located in rural areas.”;

(b) GAO STUDY AND REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall conduct a study containing the results of the study conducted under paragraph (1), together with respect to the proposed legislation and administrative action as the Comptroller General determines appropriate.

(b) RULES OF CONSTRUCTION.—This subtitle shall take into account the quality of and access to care for women and any disparities between treatments, and shall provide that any benchmark established by the Secretary of Health and Human Services to ensure regulations under the Federal Food, Drug, and Cosmetic Act that are not otherwise referenced in this subtitle or the amendments made by this subtitle.

SEC. 3022A. IMPROVEMENTS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)(1), by inserting “or critical access hospitals” before the period at the end; and

(2) in paragraph (2), by adding at the end the following new subparagraph:

“The ACO shall take into account the special needs of hospitals located in rural areas.”;

(b) GAO STUDY AND REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall conduct a study containing the results of the study conducted under paragraph (1), together with respect to the proposed legislation and administrative action as the Comptroller General determines appropriate.

(b) RULES OF CONSTRUCTION.—This subtitle shall take into account the quality of and access to care for women and any disparities between treatments, and shall provide that any benchmark established by the Secretary of Health and Human Services to ensure regulations under the Federal Food, Drug, and Cosmetic Act that are not otherwise referenced in this subtitle or the amendments made by this subtitle.
SA 2889. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1979, strike line 20 and all that follows through page 1996, line 3, and insert the following:

SEC. 9001. CAP ON EXCESS MEDICAL INFLATION.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 4890I. EXCESS MEDICAL COSTS OF HEALTH BENEFITS PLANS.

"(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

"(b) EXCESS HEALTH PLAN COSTS.—For purposes of this section—

"(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs' means, with respect to any health benefits plan which has an excess medical inflation rate in excess of zero for any year, the product of—

"(A) the applicable premium of such health benefits plan for such year, and

"(B) the excess medical inflation rate for such plan for such year.

"(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan for any year, the amount equal to the excess of—

"(A) the core medical inflation trend rate of such health benefits plan for such year, over

"(B) the medical inflation cap for such year.

"(3) CORE MEDICAL TREND RATE.—The term 'core medical trend rate' means, with respect to any health benefits plan for any year, the amount (expressed as a percentage), if any, by which—

"(A) the actuarially adjusted premium of such plan for such plan year, exceeds

"(B) the applicable premium of such plan for the preceding plan year.

"(d) MEDICAL INFLATION CAP.—

"(A) YEARS 2013 TO 2019.—

"(I) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2012 and before 2019, the medical inflation cap shall be equal to the amount (expressed as a percentage), if any, by which—

"(i) the average applicable premium for a low-cost plan in any such plan year, exceeds

"(ii) the average applicable premium for a low-cost plan in the preceding calendar year.

"(B) YEARS 2020 AND LATER.—

"(I) IN GENERAL.—For purposes of this sub-section, the term 'average applicable premium' has the meaning given such term under section 4980B(d)(4).

"(II) ADJUSTABLE PREMIUM.—

"(A) IN GENERAL.—The term 'actuarially adjusted premium' means, for any health benefits plan for any year, the applicable premium for such year adjusted, according to actuarial standards and the method prescribed by the Secretary under subparagraph (B), by excluding any cost attributable to—

"(i) the attributes of individuals (such as, gender or health risk measures) covered under the plan,

"(ii) the different categories of family structure covered under the plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

"(iii) changes in benefits or cost-sharing that result in changes the actuarial value of the plan.

"(B) METHODOLOGY.—The Secretary, in consultation with the Secretary of Health and Human Services, shall issue regulations establishing a standard methodology for adjusting a health benefits plan's applicable premium under subparagraph (A), by excluding any cost attributable to—

"(A) the core medical inflation trend rate of such health benefits plan for such year, over

"(B) the medical inflation cap for such year.

"(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

"(3) GROUP HEALTH PLAN.—The term 'group health plan' means each of the following:

"(A) a plan maintained by a group health plan issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess plan costs determined separately with respect to each product line.

"(C) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFF AMONG EMPLOYEES AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium in the preceding plan year to the coverage of health benefit plans in their previous group.

"(D) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under section 5000(b) of chapter 43 of title 26, United States Code, including similar coverage furnished under chapter 55 of title 10, United States Code, to the following:

"(1) MEMBERS OF THE ARMED FORCES AND DEPENDENTS INCLUDING TRICARE.—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 10, United States Code.

"(2) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the covered provider is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1702(a) of such title.

"(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS INCLUDING TRICARE.—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under chapter 55 of title 10, United States Code.

"(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the covered provider is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1702(a) of such title.

"(4) LIABILITIES FOR PENALTIES.—

"(A) IN GENERAL.—Each coverage provider shall pay the penalty imposed by subsection (a) into the Treasury.

"(B) GROUP HEALTH PLAN.—For purposes of this subsection, the term 'coverage provider' means each of the following:

"(A) HEALTH INSURANCE CARRIERS.—The term 'health insurance carrier' means any insurance carrier for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess plan costs determined separately with respect to each product line.

"(B) MOUNTAIN STATES HEALTH ALLIANCE.—The term 'health insurance carrier' means each of the following:

"(1) NEW YORK STATE INSURERS AND NEW EMPLOYERS.—This section shall not apply to any health benefits plan which has provided coverage for less than 12 months.

"(2) FIXED INCOME HEALTH COVERAGE PURCHASED WITH AFTER-TAX DOLLARS.—This section shall not apply to any coverage described in section 9833(c)(3)(C) for which the payment for which is not excludable from gross compensation for which a deduction under section 162 is not allowable.

"(3) CERTAIN GOVERNMENT PLANS.—This section shall not apply to the following:


"(B) MEDICARE.—Coverage for medical assistance under title XIX of the Social Security Act.

"(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS INCLUDING TRICARE.—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under chapter 55 of title 10, United States Code.

"(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the covered provider is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1702(a) of such title.

"(2) LOW-COST PLANS.—

"(A) IN GENERAL.—This section shall not apply to any health benefits plan for which the actuarial value for the plan year is not more than the applicable threshold.

"(B) APPLICABLE THRESHOLD.—For purposes of this paragraph, the applicable threshold means the dollar amount which is equal to the actuarial value of the health benefits plan which is at the 10th percentile of actuarial value for all health benefits plans.

"(C) OTHER DEFINITIONS AND SPECIAL RULES.—

"(1) HEALTH BENEFITS PLAN.—

"(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and group health plan.

"(B) GOVERNMENT PLANS INCLUDED.—Such term shall include a plan established and maintained for its civilian employees by the Government of the United States or the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

"(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The term 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b).

"(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term under section 9832(b).

"(4) REGULATIONS FOR HEALTH BENEFITS PLANS WITH DIFFERENT PRODUCT LINES.—The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for the combination of product lines of health benefits plans of any health insurance issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess plan costs determined separately with respect to each product line.

"(5) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFF AMONG EMPLOYEES AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium in the preceding plan year to the coverage of health benefit plans in their previous group.

"(6) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under section 5000(b) of chapter 43 of title 26, United States Code, including similar coverage furnished under chapter 55 of title 10, United States Code.

"(C) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2012.

SA 2890. Mr. CARPER submitted an amendment intended to be proposed to
amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 4208. WORKPLACE WELLNESS GRANTS FOR SMALL BUSINESSES.

(a) In General.—Beginning in fiscal year 2011, the Secretary of Health and Human Services (referred to in this section as the ‘Secretary’), shall make grants to eligible small businesses to provide access to comprehensive, evidence-based workplace wellness programs.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), a small business shall—

(1) employ less than 100 full or part-time employees; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary shall prescribe, that will enable the Secretary to determine the extent to which the small business program is to be carried out using grant funds.

(c) Use of Funds.—

(1) In General.—A small business shall use amounts received under a grant under this section to carry out a qualifying wellness program described in paragraph (2).

(2) Qualifying Wellness Program.—A qualifying wellness program is described in this paragraph as a program—

(A) that promotes health outcomes, as determined by the Secretary, that have proven to help alter unhealthy lifestyles and conditions (as determined by the Secretary), such as research and best practices, as determined by the Secretary; and

(B) that is carried out by using the Preventive Services and the National Guidelines for Preventive Services and the National Guidelines for Preventive Services and Guide to Community Preventive Services (referred to in this section as the ‘Guidelines’), as determined by the Secretary, such as research and best practices, as determined by the Secretary.

(3) Payment.—The amendments made by this subsection shall apply to consultation furnished on or after January 1, 2011.

SA 2891. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to make the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1240, between lines 5 and 6, insert the following:

SEC. 4208. WORKPLACE WELLNESS GRANTS FOR SMALL BUSINESSES.

(a) In General.—Beginning in fiscal year 2011, the Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall make grants to eligible small businesses to provide access to comprehensive, evidence-based workplace wellness programs.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), a small business shall—

(1) employ less than 100 full or part-time employees; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary shall prescribe, that will enable the Secretary to determine the extent to which the small business program is to be carried out using grant funds.

(c) Use of Funds.—

(1) In General.—A small business shall use amounts received under a grant under this section to carry out a qualifying wellness program described in paragraph (2).

(2) Qualifying Wellness Program.—A qualifying wellness program is described in this paragraph as a program—

(A) that promotes health outcomes, as determined by the Secretary, that have proven to help alter unhealthy lifestyles and conditions (as determined by the Secretary), such as research and best practices, as determined by the Secretary.

(3) Payment.—The amendments made by this subsection shall apply to consultation furnished on or after January 1, 2011.
lifestyles, healthy eating, physical activity and mental health).

(d) APPROPRIATIONS.—There is authorized to be appropriated, and there is authorized to be made available from the proceeds of the sale of such bonds, $20,000,000 to be used for the 5-fiscal year period beginning with fiscal year 2011.

SA 2892. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1996, between lines 3 and 4, insert the following:

SEC. 9002. CAP ON EXCESS MEDICAL INFLATION.

(a) In GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

SEC. 4986J. EXCESS MEDICAL COSTS OF HEALTH INSURANCE PLANS.

"(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

`(b) LIMITATION.—No penalty shall be imposed under subsection (a) with respect to any health benefits plan for any plan year if the excess health plan costs of such plan for such year is equal to or less than 8.2 percent.

`(c) EXCESS HEALTH PLAN COSTS.—For purposes of this section:

`(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs', means, with respect to any health benefits plan which has an excess medical inflation rate in excess of 0.2 percent for any year, the product of—

`A. the applicable premium of such health benefits plan for such year, and

`B. the excess medical inflation rate for such plan for the preceding year.

`(2) MEDICAL INFLATION RATE.—The term 'excess medical inflation rate', means, with respect to any health benefits plan for any year, the excess medical inflation rate for such plan for such year.

`(3) DETERMINATION.—The applicable premium for the preceding year for purposes of this section shall be the sum of—

`A. the applicable premium for such plan for such year,

`B. the medical inflation cap for such year,

`C. the core medical trend rate of such health benefits plan for such year, and

`D. the excess medical inflation rate for such plan for the preceding year.

`(4) MEDICAL INFLATION CAP.—The term 'medical inflation cap' means each of the following:

`(1) IN GENERAL.—(1) The annualized rate of growth of the gross domestic product for the preceding calendar year (as calculated in the third quarter of the preceding year), plus

`(2) The applicable amount.

`(5) APPLICABLE AMOUNT.—For purposes of clause (i)(II), the applicable amount shall be determined as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2.7</td>
</tr>
<tr>
<td>2014</td>
<td>2.4</td>
</tr>
<tr>
<td>2015</td>
<td>2.1</td>
</tr>
<tr>
<td>2016</td>
<td>1.8</td>
</tr>
<tr>
<td>2017, 2018, 2019</td>
<td>1.5 percentage points</td>
</tr>
</tbody>
</table>

`(6) ADMINISTRATION.—Any penalty under section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

`(7) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health insurance plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan maintained by any such government.

`(8) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS. —The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for determining the applicable premiums for any such government.

`(9) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be imposed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

`In the case of a plan year beginning in a calendar year—

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2.7</td>
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<td>1.8</td>
</tr>
<tr>
<td>2017, 2018, 2019</td>
<td>1.5 percentage points</td>
</tr>
</tbody>
</table>

`(10) ADMINISTRATION AND PROCEDURE.—Any penalty under section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

`(11) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health insurance plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan maintained by any such government.

`(12) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS. —The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for determining the applicable premiums for any such government.

`(13) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS. —The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for determining the applicable premiums for any such government.
SA 2893. Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

SEC. 3211. IMPROVEMENTS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1855(k) of the Social Security Act, as added by section 311 of this Act, is amended—

(1) in paragraph (3)—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by striking subparagraph (D), as so redesignated, by striking ‘‘(A) or (B)’’ and inserting ‘‘(A), (B), or (C)’’; and

(C) by inserting after subparagraph (B) the following new subparagraph:

‘‘(C) a county where the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for the first time is less than 45 percent (as determined by the Secretary).’’;

(2) in (5), by striking ‘‘$50,000,000’’ and inserting ‘‘$50,000,000’’.

SA 2894. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 938, strike lines 17, 18, and 19 and insert the following:

SEC. 3212. IMPROVEMENTS TO STANDARDIZED HEALTH INSURANCE REPORT CARDS.

(a) L I M I T A T I O N O N D E D U C T I O N F O R D I R E C T CO N S U M E R A D V E R T I S I N G EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

The amount allowable as a deduction under this chapter for expenses relating to direct consumer advertising in any media of prescription pharmaceuticals shall not exceed 30 percent of the amount of such expenses which would (but for this paragraph) be allowable as a deduction under this chapter.

(b) H E A L T H P R O F E S S I O N A L S T R A I N I N G F O R D E V E R S I T Y.

SEC. 1572, INCREASED FUNDING FOR WORK-FORCE PROGRAMS; LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

(a) L I M I T A T I O N O N D E D U C T I O N F O R D I R E C T TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

The amount allowable as a deduction under this chapter for expenses relating to direct consumer advertising in any media of prescription pharmaceuticals shall not exceed 30 percent of the amount of such expenses which would (but for this paragraph) be allowable as a deduction under this chapter.
(c) **Tracking Health Centers.**—Section 340F(g) of the Public Health Service Act, as added by section 505B, is amended by striking "$230,000,000" and inserting "$450,000,000".

(d) **National Health Service Corps.**—Section 338H of the Public Health Service Act, as amended by section 5207, is further amended by striking "$329,461,632" and inserting "$600,000,000".

(e) **Primary Care Training and Enhancement.**—Section 717 of the Public Health Service Act, as added by section 5301, is further amended by striking "$125,000,000" and inserting "$250,000,000".

(f) **Training in General, Pediatric, and Public Health Dentistry.**—Section 748 of the Public Health Service Act, as added by section 5303, is amended by striking "$350,000,000" and inserting "$80,000,000".

(g) **Information Technology Program.**—Section 399W(f) of the Public Health Service Act, as added by section 5405, is amended by striking "$120,000,000" and inserting "$240,000,000".

**SA 2898. Mr. Lieberman (for himself and Ms. Collins) submitted an amendment intended to be proposed to the amendment SA 2786 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyer credit for the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

**Subtitle G—Additional Health Care Quality and Efficiency Improvements**

**SEC. 3601. REPORT ON DEMONSTRATION AND PILOT PROGRAMS.**

(a) **Report.**—Not later than 12 months after the date of enactment of this Act, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a report that describes all pilot programs and demonstration projects that the Secretary has authority to carry out (regardless of whether such programs or projects are actually implemented), as authorized by law, during the period for which the report is submitted.

(b) **Requirements.**—A report under subsection (a) shall—

(1) list all pilot programs or demonstration projects involved and indicate whether each program or project is—

(A) not yet being implemented;

(B) currently being implemented; or

(C) complete and awaiting further determination;

(2) with respect to programs or projects described in subparagraphs (A) or (B) of paragraph (1), include the recommendations of the Secretary as to whether such programs or projects are necessary, and

(c) **Actions Based on Recommendations.**—Based on the recommendations of the Secretary under subsection (b)(2)—

(1) if the Secretary determines that a program or project is necessary, the Secretary shall submit to Congress a strategy to implement the program or project and may transfer such program or project into the jurisdiction of the Innovation Center for Medicare & Medicaid Services; or

(2) if the Secretary determines that a program or project is unnecessary, the Secretary shall terminate the program.

(d) **Action by Congress.**—Congress may continue in effect any program or project terminated by the Secretary under subsection (c)(2) through the enactment of a Concurrent Resolution expressing the sense of Congress to continue the program or project.

**SEC. 3602. AVAILABILITY OF DATA ON DENIAL OF CLAIMS.**

Section 2715(b)(3) of the Public Health Service Act, as added by section 1001, is amended—

(1) in subparagraph (H), by striking “and” and inserting “at the end;”;

(2) by redesignating subparagraph (I) as subparagraph (J); and

(3) by inserting after subparagraph (H) the following new subparagraph:

“(I) a statement regarding claims procedures including the percentage of claims that are annually denied by the plan or coverage and the percentage of such denials that are overturned on appeal; and”.

**SEC. 3603. ACCELERATION AND INCREASE OF THE PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.**

Section 1886(p)(4) of the Social Security Act (42 U.S.C. 1395w–4(m)), as added by section 3906A(a), is amended by—

(1) in paragraph (1)—

(A) by striking “2015” and inserting “2013”;

(B) by striking “99 percent” and inserting “98 percent”; and

(C) in paragraph (5), by striking “2015” and inserting “2013”;

**SEC. 3604. IMPROVEMENTS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.**

Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in subsection (a)(3), by striking “January 1, 2013” and inserting “January 1, 2012”; and

(2) by adding amendment (g) to read as follows:

“(g) Authority to expand implementation.—

(1) IN GENERAL.—Taking into account the evaluation under subparagraph (e), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of the pilot program, to the extent determined appropriate by the Secretary, if—

(A) the Secretary determines that such expansion will result in—

(i) reduce spending under this title without reducing the quality of care; or

(ii) improve the quality of care and reduce spending under this title.

(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this title.

(2) IMPLEMENTATION PLAN.—In the case where the Secretary does not exercise the authority under paragraph (1) by January 1, 2015, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving the quality of patient care and reducing spending under this title.”.

**SEC. 3605. ENHANCING MEDICARE BENEFICIARIES TO CHOOSE HIGH PERFORMING PROVIDERS.**

(a) **Authorization to Establish a Pilot Program to Encourage Choice of High Performing Providers.**—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) may establish a pilot program under which Medicare beneficiaries are encouraged to choose high performing providers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395w–4(m)) to participate in the Medicare program.

(b) **Availability of Information.**—Information shall be made available on such Internet website on an ongoing basis as follows:

(A) Not later than January 1, 2011, and for each subsequent year before 2015, the Internet website shall include information regarding which physicians received an incentive payment for quality reporting under section 1848(b)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)) and the information should, if the Secretary determines such expansion would improve the quality of patient care and reduce spending under the Medicare program, including such reforms under the provisions of and amendments made by this Act, in establishing such payment adjustment system under section 1848(b)(6) of such Act (42 U.S.C. 1395w–4(m)).

(B) On or after January 1, 2013, the Internet website may, as determined appropriate by the Secretary, include information on the utilization rates of physicians, as determined for purposes of section 1848(a)(8) of such Act, as added by section 3003.

(C) On or after January 1, 2014, the Internet website may, as determined appropriate by the Secretary, include information on quality measures selected by the Secretary, in consultation with the Physician Payment Advisory Committee, from among measures reported under the physician reporting system under section 1848(k) of such Act (42 U.S.C. 1395w–4(k)).

(D) On or after January 1, 2017, the Internet website shall include results of the application of the value-based payment modifier established under section 1848(b)(8) of the Social Security Act, as added by section 3007, which is required under the provisions under title XVIII of such Act, in order for Medicare beneficiaries to see how the quality and cost of services furnished by participating physicians compares to the national cost of services furnished by their peers. Such information should, if the Secretary determines appropriate, identify physicians performing in the top 50, 60, 70, and 80th percentiles as compared to their peers.

(3) **Report to Congress.**—Not later than January 1, 2019, the Secretary shall submit to Congress a report on the pilot program. The Internet website developed under this subsection, together with recommendations for such legislation and administrative actions necessary to implement such provisions under title XVIII of such Act, is added by section 3021, is amended by adding at the end the following new clause:

(4) **Expansion.**—At any time before the date on which the report is submitted under paragraph (3), the Secretary may expand the program (including expansion to other providers of services and suppliers under part B of title XVIII of the Social Security Act) the information available on such Internet website on an ongoing basis as follows:

(a) **Provision of Financial Incentives to Beneficiaries Under the Center for Medicare and Medicaid Innovation.**—Section 1121 of the Social Security Act, as added by section 2731, is amended by adding at the end the following new clause:

(b) **Development of Physician Compare Internet Website.**—

(1) **In General.**—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website for use by Medicare beneficiaries to access quality and utilization data with respect to physicians (as defined in section 1802(r) of the Social Security Act (42 U.S.C. 1395x(r))) participating in the Medicare program.

(Congressional Record — Senate December 4, 2009 S12424)
SA 2899. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

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SEC. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the re-
duction or elimination of any benefits guar-
anteed by law to participants in Medicare Advantage plans.
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SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of subtitle D of title V, insert the following:

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SEC. PME. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING PROGRAMS.

(a) IN GENERAL.—Section 768 of the Public Health Service Act (42 U.S.C. 296c) is amend-
ed to read as follows:

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SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

(a) Grants.—The Secretary, acting through the Administrator of the Health Re-
sources and Services Administration and in consultation with the Director of the Cen-
ters for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

(b) Eligibility.—To be eligible for a grant or contract under subsection (a), an entity shall be—

(1) an accredited school of public health or school of medicine or osteopathic medi-
cine;

(2) an accredited public or private non-
profit hospital;

(3) a State, local, or tribal health depart-
ment; or

(4) a consortium of 2 or more entities de-
scribed in paragraphs (1) through (3).

(c) Use of Funds.—Amounts received under a grant or contract under this section shall be—

(1) plan, develop (including the develop-
ment of curricula), operate, or participate in an accredited residency or internship pro-
gram in preventive medicine or public health;

(2) defray the costs of practicum ex-
periences, as required in such a program; and

(3) pay, or reimburse;

(A) academic administrative units (in-
cluding departments, divisions, or other ap-
propriate units) in preventive medicine and public health; or

(B) programs that improve clinical teach-
ing in preventive medicine and public health.
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SA 2901. Mr. THUNE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

SA 2902. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

On page 2040, strike line 14 and insert the following:

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(b) DOLLAR LIMIT NOT TO EXCEED COM-
pensation of the President.—

(1) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as amended by subsection (a), is amended by adding at the end the following new subpara-
graph:

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(3) the revenues resulting from the appli-
cation of section 162(m) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Sec-
curity's delegate.
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(c) EFFECTIVE DATE.—The amendments made by

SA 2903. Ms. SNOWE (for herself, Mr. DURBIN, Mr. MERKLEY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for him-
self, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 126, strike lines 10 through 16.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 167, strike lines 4 through 4, and insert the following:

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(d) NO INTERFERENCE WITH STATE RE-
gulatory Authority.—
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SA 2905. Mrs. LINCOLN (for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for him-
self, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

On page 2040, strike line 14 and insert the following:

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SA 2906. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 338, line 16, strike all through page 314, line 6, and insert the fol-
lowing:

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(1) IN GENERAL.—Except as provided in paragraph (2), nothing in this title shall be construed to preempt any State law that does not prevent the application of the provi-
sions of this title.
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(2) EXCEPTION FOR SMALL EMPLOYER MAN-
DATE.—The provisions of, and the amend-
ments made by, this title shall preempt any law enacted after the date of enact-
ment of this Act that would impose a re-
quirement on any employer with less than 50 full-time employees to, or would impose a penalty on such an employer for failing to, offer health insurance to its employees.

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(S) Ms. SNOWE submitted an
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(B) Such amount multiplied by a fraction, the numerator of which is the total number of full-time equivalent employees of the employer for the remaining taxable years in such credit period, and the denominator of which is 3.

(2) SAFE HARBOR FOR GROWING EMPLOYERS.—

(A) IN GENERAL.—Notwithstanding paragraph (1), the amount determined underparagraph (b) for the first taxable year of such amount by which it would be reduced if such reduction amount were determined by using the same fractions determined under paragraph (1) for the first taxable year of such credit period.

(B) REDUCTION IN AGGREGATE AMOUNT OF CREDITS.—For purposes of determining the amount of the credit under subsection (b) for any taxpayer to whom subparagraph (A) applies for any taxable year of the taxpayer in which the term ‘eligible small employer’ which is in effect under paragraph (2) for the taxable year, the amount of the nonelective contributions made on behalf of any employee whose annual wages exceed twice the dollar amount in effect under subsection (d)(3)(B) for such taxable year which may be taken into account under subsection (b) shall not exceed such annual wages multiplied by a fraction the numerator of which is the dollar amount so in effect and the denominator of which is such annual wages.

(C) EDSIBLE SMALL EMPLOYER.—For purposes of section 152(d)(2)(B), ‘(A) IN GENERAL.—The term ‘eligible small employer’ means, with respect to any taxable year, an employer—

(1) which has no more than 50 full-time equivalent employees for the taxable year.

(2) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under subsection (d)(3)(B) for the taxable year, and

(3) which has in effect an arrangement described in subparagraph (A) and (B), an employer which is an eligible small employer for the first taxable year in a credit period shall be treated as an eligible small employer for all remaining taxable years in such credit period.

(2) FULL-TIME EQUIVALENT EMPLOYEES.—The term ‘full-time equivalent employees’ means a number of employees equal to the number determined by dividing—

(1) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

52. (1)(i)(II) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subsection (A).

(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including the application of this paragraph to employees who are not compensated on an hourly basis.

(3) AVERAGE ANNUAL WAGES.—

(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

(1) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

(2) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B),

1. 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $25,000.

2. (II) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

4. CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make an annual contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

5. SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

(B) DEFINITION OF SEASONAL WORKER.—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and regulations employing exclusively during holiday seasons.

(C) OTHER RULES AND DEFINITIONS.—For purposes of this section—

(1) EMPLOYER.—The term ‘employer’ shall include a leased employee within the meaning of section 416(i)(1)(B)(i) of an eligible small business, or

(2) LEASED EMPLOYEES.—The term ‘employee’ shall not include—

(i) any person who bears any of the relationships described in subparagraphs (A) and (B) of section 3142(b)(2) to, or is a dependent described in section 3121(d)(2)(H) of, an individual described in clause (1), (ii), or (iii).

(iii) an individual described in clause (i) who is participating in a pilot project under this section.

(D) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of Medicare beneficiaries who begin home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(E) INCENTIVES.—

1. PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

2. ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act for medicare beneficiaries described in paragraph (1) for the prior year of the pilot project in a base period determined by the Secretary; and

(i) an annual per capita expenditure target for medicare beneficiaries. The base expenditure amount adjusted for risk and adjusted growth rates.

2. COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable beneficiaries in the same geographic area that are not determined to be within the scope of the pilot project.
(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the Medicare savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments) that a home health agency would otherwise receive under title XVIII of the Social Security Act—

(a) did not exceed the payment level for such agency under section 1861(o) of such Act (42 U.S.C. 1395x(o)); Information developed under the preceding sentence shall—

(i) include information on national, State, and community-based resources that assist individuals with disabilities and their caregivers, which shall be updated on a semi-annual basis (or as frequently as practicable);

(ii) be disseminated to health care providers, social workers, and other appropriate individuals; and

(iii) be made available on the Internet.

(b) SEC. 2407. SUPPORT FOR FAMILY CAREGIVERS UNDER MEDICARE AND MEDICAID.—

(a) MEDICARE FAMILY CAREGIVER INFORMATION AND REFERRAL.—State health insurance assistance programs, the Administrator of the Centers for Medicare and Medicaid Services, and the Assistant Secretary of the Administration on Aging shall, in collaboration with each other, promptly develop, implement, and communicate to family caregivers of Medicare beneficiaries (including those who have furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395l(a))), a comprehensive rehabilitation facility (as defined in section 1861(c)(2) of such Act (42 U.S.C. 1395x(c)(2))) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))). Information developed under the preceding sentence shall—

(i) include information on national, State, and community-based resources that assist individuals with disabilities and their caregivers, which shall be updated on a semi-annual basis (or as frequently as practicable);

(ii) be disseminated to health care providers, social workers, and other appropriate individuals; and

(iii) be made available on the Internet.

(b) Medicaid Assessment of Family Caregiver Support Needs.—

(1) IN GENERAL.—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 2461, is amended—

(A) in subsection (a), by inserting the following new subparagraph:

''(i) transportation (including transportation to or discharge from a hospital (including a discharge from a hospital emergency department which has furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395l(a))), a comprehensive rehabilitation facility (as defined in section 1861(c)(2) of such Act (42 U.S.C. 1395x(c)(2))) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))))'';

(B) in subsection (d)(2)—

(i) in subparagraph (D), by striking ''and'' and inserting ';' and''; and

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and'';

(c) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SA 2908. Ms. KLOBUCHAR (for herself and Mr. KOHL) submitted an amendment intended to be proposed to amendments SA 2907 and SA 2909 proposed by Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 492, between lines 15 and 16, insert the following:

SEC. 2407. SUPPORT FOR FAMILY CAREGIVERS UNDER MEDICARE AND MEDICAID.

(a) Medicare family caregiver information and referral.—State health insurance assistance programs, the Administrator of the Centers for Medicare and Medicaid Services, and the Assistant Secretary of the Administration on Aging shall, in collaboration with each other, promptly develop, implement, and communicate to family caregivers of Medicare beneficiaries (including those who have furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395l(a))), a comprehensive rehabilitation facility (as defined in section 1861(c)(2) of such Act (42 U.S.C. 1395x(c)(2))) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o)))). Information developed under the preceding sentence shall—

(i) include information on national, State, and community-based resources that assist individuals with disabilities and their caregivers, which shall be updated on a semi-annual basis (or as frequently as practicable);

(ii) be disseminated to health care providers, social workers, and other appropriate individuals; and

(iii) be made available on the Internet.

(b) Medicaid assessment of family caregiver support needs.—

(1) IN GENERAL.—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 2461, is amended—

(A) in subsection (a), by inserting the following new subparagraph:

''(i) transportation (including transportation to or discharge from a hospital (including a discharge from a hospital emergency department which has furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395l(a))), a comprehensive rehabilitation facility (as defined in section 1861(c)(2) of such Act (42 U.S.C. 1395x(c)(2))) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))))'';

(B) in subsection (d)(2)—

(i) in subparagraph (D), by striking ''and'' and inserting ';' and''; and

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and'';

(c) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SA 2909. Mr. NELSON of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendments SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees,

"(B) completion on a voluntary basis.—

The answering of questions under subparagraph (A) from a family caregiver shall be on a voluntary basis.

(2) Targeted support services described.—The following targeted support services are described in this paragraph:

(A) Respite care and emergency back-up services including providing relief for the individual that gives the family caregiver a break from providing such care.

(B) Individual counseling (including advice, emotional support, and telephone emotional support for the family caregiver to make well-informed decisions about how to cope with the strain of supporting the individual.

(C) Support groups, including groups which provide help for family caregivers to—

(i) locate a support group either locally or online to share experiences and reduce isolation;

(ii) make well-informed decisions about caring for the individual; and

(iii) reduce isolation.

(D) Information and assistance (including online resources for research about a disease or disability or learning and helping with the purchase of new technologies that can assist family caregivers, and practical assistance for locating services.

(E) Chore services (such as house cleaning.

(F) Personal care (including outside help).

(G) Education and training (including online workshops and other resources available with information about stress management, self-care to maintain good physical and mental health, understanding and communicating with individuals with dementia, medication management, normal aging processes, change in disease and disability, the role of assistive technologies, and other relevant topics.

(H) Legal and financial planning and consultation (including advice and counseling regarding long-term care planning, estate planning, powers of attorney, community property laws, tax advice, employment leave advice, advance directives, and end-of-life care.

(I) Transportation (including transportation to medical appointments.

(J) Other targeted support services the Secretary or the State determines appropriate.

(2) Referrals.—In the case where a questionnaire completed by a family caregiver under paragraph (2) indicates that the family caregiver would benefit from one of the targeted support services described in paragraph (3), the State shall provide referrals to the family caregiver for local, State, and private-sector family caregiver programs and other resources that provide such targeted support services.

(3) Effective date.—The amendments made by paragraph (1) shall apply to medical assistance for home and community-based services that is provided on or after the date of enactment of this Act.

SA 2909. Mr. NELSON of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees,
and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1449, strike line 1 and all that follows through page 1458, line 5, and insert the following:

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) In general.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)"; and

(2) in paragraph (4)(H)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)"; and

(b) adding at the end the following new paragraph:

"(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

(1) REDUCTION IN LIMIT BASED ON UNFUNDED POSITIONS.—

(i) In general.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had residency positions that were not funded for all or part of the most recent time period ending before the date of enactment of this paragraph by an amount that is equal to the number of such unfunded residency positions.

(ii) Exception for rural hospitals and certain other hospitals.—This subparagraph shall not apply to a hospital—

(1) located in a rural area (as defined in subsection (d)(2)(D)(ii));

(2) that has participated in a voluntary reduction plan under paragraph (6); or

(3) that submitted a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90-248.

(b) NUMBER AVAILABLE FOR DISTRIBUTION.—The number of additional residency positions available for distribution under subparagraph (B) shall be an amount that the Secretary determines would result in a 15 percent increase in the aggregate number of full-time equivalent residents in approved medical training programs as determined based on the most recent cost reports available at the time of distribution. One-third of such number shall only be available for distribution to hospitals described in subclause (I) of subparagraph (B)(ii) under such subparagraph.

(B) DISTRIBUTION.—

(i) In general.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after the date of enactment of this paragraph. The aggregate number of increments of the otherwise applicable resident limit under this subparagraph shall be equal to the number of additional residency positions available for distribution under subparagraph (B)(ii).

(ii) DISTRIBUTION TO HOSPITALS ALREADY OPERATING OVER RESIDENT LIMIT.—

(1) Notwithstanding subsection (B)(ii), in the case of a hospital in which the reference resident level of the hospital (as specified in clause (iii)) is greater than the otherwise applicable resident limit, the Secretary, in the otherwise applicable resident limit under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

(aa) the number of resident positions by which the reference resident limit of the hospital exceeds the otherwise applicable resident limit for the hospital; and

(bb) the number of resident positions by which the reference resident limit of all such hospitals with respect to which an application is approved under this subparagraph exceeds the otherwise applicable resident limit for such hospitals.

(2) REQUIREMENTS.—A hospital described in clause (i) is eligible for an increase in the otherwise applicable resident limit under this subparagraph unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent additional residency positions in primary care and general surgery (as of the date of enactment of this paragraph); and

(3) Definitions.—In this subparagraph—

(A) the term "otherwise applicable resident limit" means the resident level for the hospital for the cost reporting period that includes the additional residency positions under this paragraph that are not reserved for distribution under this clause.

(III) CLARIFICATION REGARDING ELIGIBILITY FOR OTHER ADDITIONAL RESIDENCY POSITIONS.—

(A) In general.—Except as provided in this clause, nothing in paragraphs (7) and (8) shall be construed as preventing a hospital described in clause (1) from applying for additional residency positions under this paragraph that are not reserved for distribution under this clause.

(B) DISTRIBUTION.—

(i) In general.—The Secretary shall increase the otherwise applicable resident limit for a hospital by the amount by which such limit was increased under this clause.

(ii) Reference resident level.—

(PA) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position was filled; and

(II) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

(iii) The Secretary shall give preference to hospitals that emphasize training in community health centers and other community-based clinical settings.

(III) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios).

In determining the number of medical students in a State for purposes of this paragraph, the Secretary shall include planned students at medical schools which have provisional accreditation by the Committee on Accreditation of Education for Osteopathic Profession or the American Osteopathic Association.

(iv) The Secretary shall give preference to hospitals that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

(v) LIMITATION.—

(1) In general.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(II) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

(B) INCREASE IN NUMBER OF ADDITIONAL RESIDENCY POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph by an amount that is less than such position if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital under this paragraph, the Secretary shall apply the increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(G) DISTRIBUTION.—The Secretary shall distribute the increase under this paragraph to hospitals that submit applications for additional residency positions in a hospital, subject to the following criteria:

(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions that are based on such preference, a hospital shall ensure that—

(ii) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position was filled; and

(iii) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirements of subparagraph (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph.

(iii) The Secretary shall give preference to hospitals that emphasize training in community health centers and other community-based clinical settings.

(III) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios).

In determining the number of medical students in a State for purposes of this paragraph, the Secretary shall include planned students at medical schools which have provisional accreditation by the Committee on Accreditation of Education for Osteopathic Profession or the American Osteopathic Association.

(iv) The Secretary shall give preference to hospitals that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

(E) LIMITATION.—

(1) In general.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(II) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

(B) INCREASE IN NUMBER OF ADDITIONAL RESIDENCY POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph by an amount that is less than such position if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(G) DISTRIBUTION.—The Secretary shall distribute the increase under this paragraph to hospitals that submit applications for additional residency positions in a hospital, subject to the following criteria:

(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions that are based on such preference, a hospital shall ensure that—

(ii) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position was filled; and

(iii) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirements of subparagraph (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph.

(iii) The Secretary shall give preference to hospitals that emphasize training in community health centers and other community-based clinical settings.

(III) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios).

In determining the number of medical students in a State for purposes of this paragraph, the Secretary shall include planned students at medical schools which have provisional accreditation by the Committee on Accreditation of Education for Osteopathic Profession or the American Osteopathic Association.

(iv) The Secretary shall give preference to hospitals that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

(E) LIMITATION.—

(1) In general.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(II) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

(B) INCREASE IN NUMBER OF ADDITIONAL RESIDENCY POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph by an amount that is less than such position if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.
subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under subsection (h)(8) (B) with respect to such resident positions."

SA 2910. Mr. FRANKEN (for himself, Mr. ROCKEFELLER, Mrs. LINCOLN, Mr. WHITEHOUSE, Mr. LEAHY, Mr. SANDERS, Mr. BROWN, and Mr. BEGICH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. Baucus, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 1003, insert the following:

SEC. 1004. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

(a) IN GENERAL.—Section 2718 of the Public Health Service Act, as added by section 1001, is amended to read as follows:

``SEC. 2718. DEFINING DOWN THE COST OF HEALTH CARE COVERAGE.

``(a) CLEAR ACCOUNTING FOR COSTS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expenditure—

``(1) on reimbursement for clinical services provided to enrollees under such coverage;

``(2) for activities that improve health care quality;

``(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or property fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

``(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

``(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—(A) In general.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual report to each enrollee that describes the health care services and the premium revenue expended by the plan or issuer on activities described in subsection (a)(3) exceeds 10 percent, or such lower percentage as the State may by regulation determine.

``(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by group health plans and health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

``(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

``(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public, in accordance with guidelines developed by the Secretary, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

``(d) DEFINITIONS.—Not later than December 31, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions of the activities described under subsection (a) and standardized methodologies for calculating measures of such activities.

``(b) TECHNICAL AMENDMENTS.—

``(1) ERISA.—Section 602(b) of the Employee Retirement Income Security Act, as amended by section 1562(e), is further amended by adding—

``(A) at the end of subsection (b), the following:

``(B) ``(D) a freestanding psychiatric hospital with 90 percent or more inpatients under the age of 18, that has its own Medicare provider number as of December 6, 1999, and that has an accredited residency program.''

SA 2911. Mr. FRANKEN (for himself and Mr. Lugar) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, insert the following:

SEC. 4208. NATIONAL DIABETES PREVENTION PROGRAM.

Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 5455, is further amended by adding at the end the following:

``SEC. 399V-2. NATIONAL DIABETES PREVENTION PROGRAM.

``(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the 'program') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

``(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

``(1) a program for community-based diabetes prevention model sites;

``(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention model sites;

``(3) a training and outreach program for lifestyle intervention instructors; and

``(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

``(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and health-related outcomes for women and their families, or other entity, as the Secretary determines.

``(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''

SA 2912. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. 5510. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

Subpart IX of part D of title III of the Public Health Service Act (42 U.S.C. 256 et seq.) is amended—

``(1) in the subpart heading, by adding 'and Women's Hospitals' at the end; and

``(2) by adding at the end the following:

``SEC. 340E-1. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

``(a) PAYMENTS.—The Secretary shall make two payments under this section to each women's hospital for each of fiscal years 2010 through 2014, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.

``(b) AMOUNT OF PAYMENTS.—

``(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amounts payable under this section shall be each of the amounts payable under section (c) for indirect expenses associated with operating approved graduate medical residency training programs for a fiscal year shall be each of the following:

``(A) DIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for direct expenses associated with operating approved graduate medical residency training programs for a fiscal year shall be each of the following:

``(B) INDIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for indirect expenses associated with operating approved graduate medical residency training programs for a fiscal year shall be each of the following:

``(C) CAPPED AMOUNT.—

``(A) IN GENERAL.—The total of the payments made to women's hospitals under
paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the funds appropriated under subsection (e) for such payments for that fiscal year.

(2) VARYING PROPORTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (e) for a fiscal year is insufficient to provide for each hospital for the financial year for both the direct and indirect expense amounts, the Secretary shall determine, before the beginning of each fiscal year, the proportion of such amounts that shall be paid to each hospital for the current fiscal year to determine any changes to the number of residents trained during the hospital's financial year.

(3) ANNUAL REPORTING REQUIRED.—The provisions of subsections (b)(3) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

(d) DEFINITIONS.—

"(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year, the amount for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and the amount that must be paid for each hospital for the financial year.

"(2) IN GENERAL.—(A) The Secretary of Health and Human Services shall determine, before the beginning of each fiscal year, the number of residents trained during the hospital's financial year to determine the amount that must be paid for each hospital for the financial year.

"(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means—

"(A) that has a Medicare provider agreement under title XVII of the Social Security Act;

"(B) that has an approved graduate medical residency training program;

"(C) that is certified by the Medicare prospective payment system;

"(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

"(E) with respect to which and as determined by the Secretaries for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

"(4) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulations) to the Secretary and the Secretary of Health and Human Services, in the case of an entity that is a hospital that does not report such information to the Secretary through regulations, shall annually submit a report (in a manner to be established by the Secretary through regulations) to the Secretary and the Secretary of Health and Human Services, in the case of a hospital that does not report such information, with respect to such hospital, increased by the amount equal to the excess of—

"(i) the amount determined under subparagraph (b), and

"(ii) the amount determined under subparagraph (c).

"(5) CARRYING FORWARD.—The Secretary shall determine, before the beginning of each fiscal year, the amount of the amounts determined under subsections (c) and (d) that shall carry forward to each fiscal year to reduce the fee determined under subsection (b).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section for each of fiscal years 2011 through 2014.

(f) DEFINITIONS.—In this section:

"(1) MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(b)(5) of the Social Security Act.

"(2) INDIRECT EXPENSE AND INDIRECT EXPENSE COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.

"(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means—

"(A) that has a Medicare provider agreement under title XVII of the Social Security Act;

"(B) that has an approved graduate medical residency training program;

"(C) that is certified by the Medicare prospective payment system;

"(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

"(E) with respect to which and as determined by the Secretaries for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

"(4) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulations) to the Secretary and the Secretary of Health and Human Services, in the case of an entity that is a hospital that does not report such information.

"(5) AMOUNT OF FEE INCREASE.—

"(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall not exceed the amount established under paragraph (1)(A).

"(B) PENALTY AMOUNT.—

"(1) IN GENERAL.—The penalty amount shall be the product of—

"(i) the amount determined under subsection (b), and

"(ii) the medical loss ratio threshold (expressed in decimal form) of the penalized covered entity.

"(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this paragraph is the amount equal to the excess of—

"(i) the medical loss ratio threshold established under paragraph (2)(A), over

"(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

"(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

"(i) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

"(ii) the fee redistribution ratio.

"(E) RECOUPMENT.—The Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

"(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year, the amount for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and the amount that must be paid for each hospital for the financial year.

"(2) IN GENERAL.—(A) The Secretary of Health and Human Services shall determine, before the beginning of each fiscal year, the number of residents trained during the hospital's financial year to determine the amount that must be paid for each hospital for the financial year.

"(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means—

"(A) that has a Medicare provider agreement under title XVII of the Social Security Act;

"(B) that has an approved graduate medical residency training program;

"(C) that is certified by the Medicare prospective payment system;

"(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

"(E) with respect to which and as determined by the Secretaries for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

"(4) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulations) to the Secretary and the Secretary of Health and Human Services, in the case of an entity that is a hospital that does not report such information.

"(5) AMOUNT OF FEE INCREASE.—

"(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall not exceed the amount established under paragraph (1)(A).

"(B) PENALTY AMOUNT.—

"(1) IN GENERAL.—The penalty amount shall be the product of—

"(i) the amount determined under subsection (b), and

"(ii) the medical loss ratio threshold (expressed in decimal form) of the penalized covered entity.

"(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this paragraph is the amount equal to the excess of—

"(i) the medical loss ratio threshold established under paragraph (2)(A), over

"(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

"(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

"(i) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

"(ii) the fee redistribution ratio.

"(E) RECOUPMENT.—The Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.
(D) Medical Loss Ratio Component.—The amount determined under this subparagraph is the amount equal to the excess of—
(i) the medical loss ratio (expressed as a percentage) of the covered entity, over
(ii) the medical loss ratio threshold established under paragraph (2)(A).
(E) Financial Reserve Component.—The amount determined under this subparagraph is the amount equal to the ratio of—
(i) the excess of—
(I) the maximum financial reserve threshold established under paragraph (2)(B)(i), over
(II) the financial reserves of the covered entity, to
(II) such maximum financial reserve threshold.
SA 2915. Mrs. SHAHEEN (for herself, Mr. Brown, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of certain non-retired Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 531, line 2, insert the following after the period: "In awarding planning grants, the Secretary shall give preference to States that agree to develop a State plan that includes methodologies and procedures that are intended to improve coordination of care for eligible individuals with chronic conditions who are users of health care services, including through the use of referrals to health homes and outreach care management services."

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of certain Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 531, line 2, insert the following after the period: "In awarding planning grants, the Secretary shall give preference to States that agree to develop a State plan that includes methodologies and procedures that are intended to improve coordination of care for eligible individuals with chronic conditions who are users of health care services, including through the use of referrals to health homes and outreach care management services."

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 33, strike line 5 and all that follows through line 4 on page 34 and insert the following:

"SEC. 2719. APPEALS PROCESS.
(a) Interest Claims Appeals.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for determinations and claims, under which the plan or issuer shall, at a minimum—
(1) have in effect an internal claims appeal process;
(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2799A of the Public Health Service Act, or "after located";
(3) allow the enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.
(b) External Review.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—
(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or
(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1).
(2) Special Rule Regarding Prenancy.—An individual who becomes pregnant and is enrolled in a catastrophic plan described under this subsection may, notwithstanding any other provision of law, enroll in another qualified health plan during such individual’s pregnancy.
SA 2918. Mr. MENENDEZ (for himself, Mr. STABENOW, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 156, between lines 13 and 14, insert the following:

(c) Payments to Federally-Qualified Health Centers.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(a)(29) of the Social Security Act (42 U.S.C. 1396a(a)(29))) to an enrollee of the plan, and the cost of such item or service shall be paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 23, strike line 5 and all that follows through line 4 on page 34 and insert the following:

"SEC. 2719. APPEALS PROCESS.
(a) Interest Claims Appeals.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for determinations and claims, under which the plan or issuer shall, at a minimum—
(1) have in effect an internal claims appeal process;
(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2799A of the Public Health Service Act, or "after located";
(3) allow the enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.
(b) External Review.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—
(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or
"(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1).
(2) Special Rule Regarding Prenancy.—An individual who becomes pregnant and is
SEC. 1412. INVESTMENT INCOME.

"(a) In General.—For purposes of this chapter, the term 'investment income' means the sum of:

(1) capital gain net income, and

(2) net investment income.

(b) Net Investment Income.—For purposes of this chapter, the term 'net investment income' means the net income (other than income which is included in self-employment income for purposes of chapter 2) from—

(1) dividends,

(2) interest (other than interest which is excludable from income under chapter 1), and

(3) investment property income.

(c) Investment Property.—For purposes of this chapter, the term 'investment property income' means income (determined after taking into account any deduction allowed under chapter 1 with respect to such income) derived from—

(1) any property held for the production of rents or royalties,

(2) any partnership or S corporation, or

(3) any estate or trust in which the taxpayer is a beneficiary, and

(4) any real estate mortgage investment conduit in which the taxpayer is a residual investor.

(2) TAXABLE YEARS ENDING AS THE RESULT OF A DEATH.—Rules similar to the rules of section 1402(f) shall apply with respect to investment income in a taxable year which ends as a result of the death of the taxpayer.

(3) ESTIMATED TAXES.—Section 6655 of the Internal Revenue Code of 1986 is amended—

(A) by striking '10 percent' and inserting '1 percent' before 'under chapter 2' and inserting ''the tax prescribed by chapter 2'' and inserting ''the tax prescribed by chapter 4'',

(B) by redesigning section 6655A, redesigning paragraph (3), and redesigning paragraph (5),

(C) by inserting the following new paragraph:

"(3) the total of the estimated tax imposed for each calendar quarter of the taxable year which ends as a result of the death of the taxpayer","n

(4) RETURNS.—(A) In General.—For purposes of this section, "taxable year" includes—

(i) the taxable year of the taxpayer,

(ii) the taxable year of any Liechtenstein trust or fiduciary of the taxpayer,

(iii) the taxable year of any United States trust of the taxpayer,

(iv) the taxable year of any foreign trust of the taxpayer for which the United States is the conduit in which the taxpayer is a residual investor,

(v) the taxable year of any conduit in which the taxpayer is a beneficiary, and

(vi) the taxable year of any United States trust of the taxpayer for which the United States is the conduit in which the taxpayer is a residual investor.

(5) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

SEC. 2903. FUNDING FOR CONTRACT MEDICAL CARE FOR INDIANS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1681 et seq.) is amended by adding at the end the following:

"SEC. 826. FUNDING FOR CONTRACT MEDICAL CARE.

"(a) Appropriation.—For the purpose of the Secretary, acting through the Service, providing payment for contract medical care to Indians, there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed—

(1) for fiscal year 2010, $625,000,000;

(2) for fiscal year 2011, $2,500,000,000;

(3) for each of fiscal years 2012 through 2014, the limit specified under this subsection for the preceding fiscal year, increased by the percentage increase, if any, in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year;

and

(4) for the first quarter of fiscal year 2015, one-fourth of the limit specified under this subsection for fiscal years 2010 through 2014, increased by the percentage increase, if any, in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year.

"(b) No Effect on Other Funding for this Act; Availability.—Funds appropriated under subsection (a) shall—

(1) be in addition to any other amounts made available under law (including under a
provision of this Act, the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or any other law) for payment for providing contract medical care to Indians; and
“(2) remain available until expended.
“(c) STUDY AND REPORT.—Not later than October 1, 2015, the Secretary shall study and submit a report to the Committee on Natural Resources of the House of Representatives and the Committee on Indian Affairs of the Senate on the extent to which the funds appropriated under this section have assisted in reducing health disparities among Indians.
“(d) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for payment of the amounts provided under subsection (a).
“(e) DEFINITION.—In this section, the term ‘Indian health program’ means—
“(1) any health program administered directly by the Service;
“(2) any tribal health program; and
“(3) any Indian tribe or tribal organization to which the Secretary of Health and Human Services provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the ‘Buy Indian Act’).”.

Rep. John D. Dingell (D-Mich.) offered an amendment intended to be offered to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. Whitehouse, Mr. Udall of New Mexico, Mr. Begich, Mr. Johnson, Mr. Franken, Ms. Cantwell, Mr. Udall of Colorado, Mr. Tester, and Mr. Inouye) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the tax treatment for certain benefits programs.

At the end, add the following:

DIVISION B—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND EXTENSION

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Indian Health Care Improvement Reauthorization and Extension Act of 2009”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SUBTITLE A—Indian Health Care Improvement Act Reauthorization and Extension

Sec. 101. Reauthorization.
Sec. 102. Findings.
Sec. 103. Declaration of national Indian health policy.
Sec. 104. Definitions.

Subtitle B—Indian Health Manpower

Sec. 111. Community Health Aide Program.
Sec. 112. Health professional chronic shortage demonstration programs.
Sec. 113. Exemption from payment of certain fees.

Subtitle C—Health Services

Sec. 121. Indian Health Care Improvement Fund.
Sec. 122. Catastrophic Health Emergency Fund.
Sec. 123. Diabetes prevention, treatment, and control.
Sec. 124. Other authority for provision of services; shared services for long-term care.

Sec. 125. Reimbursement from certain third parties of costs of health services.
Sec. 126. Crediting of reimbursements.
Sec. 127. Behavioral health training and community education programs.
Sec. 128. Cancer screenings.
Sec. 129. Patient travel costs.
Sec. 130. Epidemiology centers.
Sec. 131. Indian medical training program.
Sec. 132. American Indians Into Psychology Program.
Sec. 133. Prevention, control, and elimination of communicable and infectious diseases.
Sec. 134. Methods to increase clinician recruitment and retention issues.
Sec. 135. Liability for medical treatment.
Sec. 136. Offices of Indian Men’s Health and Indian Women’s Health.
Sec. 137. Contract health service administration and disbursement formula.

Subtitle C—Health Facilities

Sec. 141. Health care facility priority system.
Sec. 142. Indian health care delivery demonstration projects.
Sec. 143. Tribal health demonstration projects.
Sec. 144. Other funding, equipment, and supplies.
Sec. 145. Indian health care facilities demonstration program.
Sec. 146. Mobile health stations demonstration program.

Subtitle D—Access to Health Services

Sec. 151. Treatment of payments under Social Security Act health benefit programs.
Sec. 152. Purchasing health care coverage.
Sec. 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs.
Sec. 154. Sharing arrangements with Federal agencies.
Sec. 155. Eligible Indian veteran services.
Sec. 156. Nondiscrimination under Federal health benefit programs in qualifications for reimbursement for services.
Sec. 157. Access to federal insurance.
Sec. 158. General exceptions.
Sec. 159. Navajo Nation Medicaid Agency feasibility study.

Subtitle E—Health Services for Urban Indians

Sec. 161. Facilities renovation.
Sec. 162. Treatment of certain demonstration projects.
Sec. 163. Requirement to confer with urban Indian organizations.
Sec. 164. Expanded program authority for urban Indian organizations.
Sec. 165. Community health representatives.
Sec. 166. Use of Federal Government facilities and resources for health information technology.

Subtitle F—Organizational Improvements

Sec. 171. Establishment of the Indian Health Service as an agency of the Department of Health and Human Services.
Sec. 172. Office of Direct Service Tribes.
Sec. 173. Nevada area office.

Subtitle G—Behavioral Health Programs

Sec. 181. Behavioral health programs.

Subtitle H—Miscellaneous

Sec. 191. Confidentiality of medical quality assurance records; qualified immunization registry.

Sec. 199. Traditional health care practices.
Sec. 199A. Other GAO reports.
Sec. 199B. Other reports.
Sec. 200. Reauthorization of Native Hawaiian health care programs.
Sec. 201. Medicare amendments.
Sec. 202. Reauthorization of Native Hawaiian health care programs.

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND AMENDMENTS

SEC. 101. REAUTHORIZATION.

(a) IN GENERAL.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 168b(b)) is amended to read as follows:

“SEC. 825. AUTHORIZATION OF APPROPRIATIONS.

“ ‘There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.’.”

(b) REPEALS.—The following provisions of the Indian Health Care Improvement Act are repealed:

(2) Paragraph (6) of section 209(m) (25 U.S.C. 1621h(1)).
(3) Subsection (g) of section 211 (25 U.S.C. 1621).
(4) Subsection (e) of section 216 (25 U.S.C. 1621i).
(8) Subsection (c) of section 512 (25 U.S.C. 1660a).
(10) Section 603 (25 U.S.C. 1663).
(12) CONFORMING AMENDMENTS.—
(1) Section 204(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1621c(c)(1)) is amended by striking “through fiscal year 2000” and substituting “through fiscal year 2010”.
(2) Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621l) is amended by striking “(a) The Secretary” and inserting “The Secretary”.
(3) Section 310 of the Indian Health Care Improvement Act (25 U.S.C. 168bb) is amended by striking “funds provided pursuant to the authority contained in section 309” each place it appears and inserting “funds made available to carry out this title”.

SEC. 102. FINDINGS.

Section 2 of the Indian Health Care Improvement Act (25 U.S.C. 1610) is amended—

(1) by redesignating subsections (a), (b), (c), and (d) as paragraphs (1), (3), (4), and (5), respectively, and indenting the paragraphs appropriately; and
(2) by inserting after paragraph (1) (as so redesignated) the following:

“(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will reduce the health disparities between Indians and the general population of the United States.”.
SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

Section 3 of the Indian Health Care Improvement Act of 1988 (42 U.S.C. 1601) is amended to read as follows:

"SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

"(a) In general.—The term 'Indian health program' means—

"(1) any health program administered directly by the Service;

"(2) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program;

"(3) by striking paragraph (8) (as redesignated by paragraph (3)) and inserting the following:

"(1) the reduction, limitation, and prevention of—

"(i) disease; and

"(ii) complications of disease; and

"(3) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor initiatives; and

"(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals on the Service area is raised to at least the level of that of the general population;

"(5) by inserting a heading the text of which is "in this Act"; and

"(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

"(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations, and conference with Indian tribes and tribal organizations to implement this Act and the national policy of Indian self-determination;

"(8) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with Indian tribes and tribal organizations to implement this Act and the national policy of Indian self-determination;

"(9) to provide for funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service."

SEC. 104. DEFINITIONS.

Section 4 of the Indian Health Care Improvement Act of 1988 (25 U.S.C. 1608) is amended—

"(1) by the addition of clauses following "(c)" as follows:

"(2) in each of subsections (c) and (d), by redesigning the paragraphs contained in the subsections as subparagraphs and indenting the subparagraphs appropriately;

"(3) by redesigning subparagraphs (a) through (q) as paragraphs (17), (18), (13), (14), (16), (17), (18), (19), (20), (21), and (9), respectively, indenting the paragraphs appropriately, and moving the paragraphs so as to appear in numerical order;

"(4) in each paragraph (as so redesignated), by inserting a heading the text of which is comprised of the term defined in the paragraph; and

"(5) by inserting "The term" after each paragraph heading;

"(6) by inserting after paragraph (1) (as redesignated by paragraph (4)) the following:

"(2) Behavioral Health.—

"(a) In general.—The term 'behavioral health' means the blending of substance (alcohol, tobacco use, mental health disorders) and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

"(B) Junior or community college.—The term 'junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e))."

"(15) Junior or community college.—The term 'junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e))."

"(16) Reservation.—

"(A) In general.—The term 'reservation' means a reservation, Pueblo, or colony of any Indian tribe.

"(B) Inclusions.—The term 'reservation' includes—

"(i) any tribal health program; and

"(ii) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(17) Promise Indian.—The term 'Promise Indian' means any Indian who is eligible for health services provided by the Service pursuant to section 809.

"(18) Community college.—The term 'community college' means—

"(A) a tribal college or university; or

"(B) a junior or community college.

"(19) Contract health service.—The term 'contract health service' means any health service that is—

"(A) delivered based on a referral by, or at the expense of, an Indian health program; and

"(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

"(20) Department.—The term 'Department', unless otherwise designated, means the Department of Health and Human Services; and

"(21) Disease prevention.—

"(A) in general.—The term 'disease prevention' means any activity for—

"(i) the reduction, limitation, and prevention of—

"(ii) disease; and

"(iii) the reduction of consequences of disease; and

"(B) Inclusions.—The term 'disease prevention' includes an activity for—

"(i) controlling—

"(A) the development of diabetes; and

"(ii) high blood pressure; and

"(B) educating patients; and

"(iv) increasing knowledge and providing valid information.

"(22) Disease prevention—

"(A) Community college.—The term 'community college' means—

"(i) community college; and

"(ii) a college or university.

"(B) Contract health service.—The term 'contract health service' means—

"(i) a health service that is—

"(A) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program, and

"(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program; and

"(C) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

"(23) Environmental health.—The term 'environmental health' includes the joint development of healthy' includes the joint development of healthy and urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

"(12) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(13) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(14) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(15) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(16) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(17) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(18) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(19) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."

"(20) Indian health program.—The term 'Indian health program' means—

"(A) any health program administered directly by the Service;

"(B) any tribal health program; and

"(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (43 U.S.C. 294) (commonly known as the 'Buy Indian Act')."
Title 'Telehealth.'—The term ‘telehealth’ has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c(a)).

24. Tribal College or University.—The term ‘tribal college or university’ has the meaning given the term in section 3(a) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

25. Tribal Health Program.—The term ‘tribal health program’ means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(13) by striking paragraph (26) (as redesignated by paragraph (3)) and inserting the following:

26. Tribal Organization.—The term ‘tribal organization’ has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b-1).''

Subtitle A—Indian Health Manpower
SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.
Section 119 of the Indian Health Care Improvement Act (25 U.S.C. 1618a) is amended to read as follows:

SEC. 119. COMMUNITY HEALTH AIDE PROGRAM.
(a) GENERAL PURPOSES OF PROGRAM.—Pursuant to Title I of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in the State of Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses those aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(3) provides for the establishment of tele-conferencing in health clinics located in or near those villages for use by community health aides or community health practitioners.

(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that those aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

(2) in order to provide such training, develop a curriculum that—

(A) combines education regarding the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) achieves the health status objectives specified in section 3(2);

(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have completed the training described in paragraph (1) or can demonstrate equivalent experience;

(4) develop and maintain a system that identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to ensure the provision of quality health care, health promotion, and disease prevention services; and

(7) ensure—that—

(A) pulp therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment; and

(B) dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, subject to the condition that uncomplicated extractions shall not be considered oral surgery under this section.

(c) PROGRAM REVIEW.—

(1) NEUTRAL PANEL.—(A) Establishment.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

(2) STUDY.—

(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

(c) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

(i) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

(ii) whether safer and less costly alternatives to the dental health aide therapist services exist.

(d) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska tribal organizations with respect to the adequacy and accuracy of the study.

(e) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

(A) any determination of the neutral panel under paragraph (2)(C); and

(B) any comments received from Alaska tribal organizations under paragraph (2)(D).

(d) NATIONALIZATION OF PROGRAM.—(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

(2) REQUIREMENT; EXCLUSION.—In establishing a national program under paragraph (1), the Secretary—

(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and

(B) shall exclude dental health aide therapist services from services covered under the program.

SEC. 112. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.
Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.
(a) DEMONSTRATION PROGRAMS.—The Secretary, acting through the Service, may fund demonstration programs for Indian health programs to address the chronic shortages of health professionals.

(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs under subsection (a) shall be—

(1) to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools;

(2) to improve the quality of health care for Indians by ensuring access to qualified health professionals;

(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region; and

(4) to provide training and support for alternative provider types, such as community health representatives, and community health aides.

(c) ADVISORY BOARD.—The demonstration programs established under subsection (a) shall incorporate a program advisory board, which may be composed of representatives of tribal governments, Indian health programs, and Indian areas to be served by the demonstration programs.

SEC. 113. EXEMPTION FROM PAYMENT OF CERTAIN FEES.
Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 112(b)) is amended by adding at the end the following:

SEC. 124. EXEMPTION FROM PAYMENT OF CERTAIN FEES.
"Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by any agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees."

Subtitle B—Health Services
SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.
Section 201 of the Indian Health Care Improvement Act (25 U.S.C. 1611) is amended to read as follows:

SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.
(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend...
funds, directly or under the authority of the
Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section shall be designated as the 'Indian Catastrophic Health Emergency Fund'.

SEC. 123. DIABETES PREVENTION, TREATMENT, AND CONTROL.

Section 27 of the Indian Health Care Improvement Act (25 U.S.C. 1621a) is amended to read as follows:

SEC. 122. CATASTROPHIC HEALTH EMERGENCY FUND.

(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

(1) the amounts deposited under subsection (f); and

(2) the amounts appropriated to CHEF under this section.

(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses which are within the responsibility of the Service.

(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a threshold cost which the Secretary shall establish at—

(A) the 2000 level of $19,000; and

(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

(3) establish a procedure for the reimbursement of the portion of the costs that exceed such threshold cost incurred by—

(A) Service Units; or

(B) whenever otherwise authorized by the Service, non-Federal contractors.

(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

(c) ALLOCATION; USE.—

(1) IN GENERAL.—Funds appropriated under the authority of this Act shall be used to offset or limit any other provision of law.

(2) NO OFFSET OR LIMITATION.—Any funds appropriated to CHEF under this section in subsection (a) shall be included in the base budget of each Service Unit, or other similar basis.

(3) REPORT.—No later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall prepare and submit to the House of Representatives a report detailing the amount and purpose of funds appropriated under this section.

(b) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(1) ELIGIBILITY.—Any funds appropriated under the authority of this Act, or any other Act, are subject to contract or grant under any law, in- cluding the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

(2) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(2) A PORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to CHEF under this section shall be made as follows:

(a) The amount of health service funds appropriated under the authority of this Act, or any other Act, are subject to contract or grant under any law, in- cluding the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

(3) PROCESS FOR REVIEW OF DETERMINATIONS.—CHEF shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiencies of such Indian tribe or tribal organization.

(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other provision of law.

(1) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(2) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(3) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(4) ELIGIBILITY FOR FUNDS.—Trihal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other provision of law.

(c) ALLOCATION; USE.—

(1) IN GENERAL.—Funds appropriated under the authority of this Act shall be used to offset or limit any other provision of law.

(2) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other provision of law.

(3) REPORT.—No later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall prepare and submit to the House of Representatives a report detailing the amount and purpose of funds appropriated under this section.
“(a) DETERMINATIONS REGARDING DIABETES.—The Secretary shall, acting through the Service, and in consultation with Indian tribes and tribal organizations, determine—

(1) by Indian tribe and by Service unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and ongoing monitoring of disease indicators) each Service unit shall undertake to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that Service unit.

(b) Screening.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a tribal health program and may be conducted through appropriate telehealth-based health care management programs.

(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, any such other diabetes programs operated by the Service or tribal health programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–67, as implemented to screen and monitor for diabetes and diabetes-related complications. Such diabetes programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 and for projects which are added and funded thereafter.

(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian tribes, and tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

(e) OTHER DUTIES OF THE SECRETARY.—

(1) of the Secretary shall, to the extent funding is available—

(A) in each area office, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

(B) establish in each area office a registry of patients with diabetes to track the incidence and complications from diabetes in that area; and

(C) ensure that data collected in each area office regarding diabetes and related complications among Indians are disseminated to all other area offices, subject to applicable patient privacy laws.

(2) DIABETES CONTROL OFFICERS.—

(A) IN GENERAL.—The Secretary may establish and maintain in each area office a position of diabetes control officer to coordinate and manage any activity of that area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 338 of the Public Health Service Act (42 U.S.C. 256c) by entering into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians.

(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be deivable for purposes of that Act.

(3) Right of Recovery.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance provider other than governmental entities, including the Medicare program, any reasonable charges billed by the Secretary, the United States, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, including the Medicare program, to an individual to the extent that such individual, or any nongovernmental provider of such services, would be eligible for the non-federal share of the cost of those services.
to receive damages, reimbursement, or indemnification for such charges or expenses if—

(1) such services had been provided by a nonfederal health provider; and

(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

(b) LIMITATION ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers’ compensation laws; or

(2) a no-fault automobile accident insurance plan or program.

(2) NONAPPLICABILITY OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

(3) SELF-INSURANCE PLANS.—Where such authorizations by the governing body of an Indian tribe or tribal organization are provided under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization. Where such authorizations are provided under a self-insurance plan, managed care plan, or contract, insurance or health maintenance organization, respectively, and may be used as a credit toward any reimbursement received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provisions of any applicable, Federal, State, or local law (whether such laws are of a general or specific nature).

SEC. 126. CREDITING OF REIMBURSEMENTS.

Section 207 of the Indian Health Care Improvement Act (25 U.S.C. 1621j) is amended to read as follows—

SEC. 207. CREDITING OF REIMBURSEMENTS.

(a) USE OF AMOUNTS.—

(1) RETENTION BY PROGRAM.—Except as provided in paragraphs (2) and (3), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provisions of any applicable, Federal, State, or local law (whether such laws are of a general or specific nature), shall be credited to the Service, by an Indian tribe or tribal organization, or by an urban Indian organization, shall be credited to the Service, such Indian tribe or tribal organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

(A) grants in paragraphs VIII, XIX, and XXI of the Social Security Act.

(B) This Act, including section 813.

(C) Public Law 87–983.

(2) ANY OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).”.

SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

Section 209 of the Indian Health Care Improvement Act (25 U.S.C. 1621h) is amended by striking subsection (d) and inserting the following:

Behavioral Health Training and Community Education Programs.

(1) STUDY.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian tribes and tribal organizations, shall conduct a study and compile a list of the types of training operations specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self-destructive behavior.

(2) POSITIONS.—The positions referred to in paragraph (1) are—

(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

(i) elementary and secondary education;

(ii) social services and family and child welfare;

(iii) law enforcement and judicial services; and

(iv) alcohol and substance abuse;

(B) staff positions within the Service; and

(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes and tribal organizations (without regard to the funding source).

(3) TRAINING CRITERIA.—

(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraphs (2)(A) and (B) established and maintained by appropriate individual positions. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

(B) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria should be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

(4) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement a request of the appropriate Secretary, the Indian tribe, tribal organization, or urban Indian organization, or assist the Indian tribe, tribal organization, or urban Indian organization to develop and implement, a part of the program of community education on mental illness. In carrying out this paragraph, the Service shall, upon request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization to obtain and develop community education materials on mental illness, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

(5) NOT LATER THAN 90 DAYS.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension
Act of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 1 year of enactment of that Act, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this paragraph shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’)."

SEC. 214. EPIDEMIOLOGY CENTERS.

Section 214 of the Indian Health Care Improvement Act (25 U.S.C. 1621k) is amended by inserting ‘and other cancer screenings’ before the period at the end.

SEC. 215. PATIENT TRAVEL COSTS.

Section 215 of the Indian Health Care Improvement Act (25 U.S.C. 1621l) is amended to read as follows:

SEC. 215. PATIENT TRAVEL COSTS.

‘‘(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term ‘qualified escort’ means—

‘‘(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient; or

‘‘(2) a medical professional for the purpose of providing necessary medical care during travel by the applicable patient; or

‘‘(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

‘‘(b) Provision of Funds.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act:

‘‘(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

‘‘(2) transportation by private vehicle (where no means of transportation is available), specially equipped vehicle, and ambulance; and

‘‘(3) transportation by such other means as may be required when air or motor vehicle transportation is not available.’’.

SEC. 210. EPIDEMIOLOGY CENTERS.

Section 210 of the Indian Health Care Improvement Act (25 U.S.C. 1621j) is amended to read as follows:

SEC. 210. EPIDEMIOLOGY CENTERS.

‘‘(a) Establishment of Centers.—

‘‘(1) IN GENERAL.—An epidemiology center shall be established under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’) .’’

‘‘(2) FUNDS NOT DIVISIBLE.—An epidemiology center established under this subsection shall not be divisible.

‘‘(3) Determination and Education Assistance Act.—

‘‘(A) demonstrate the technical, administrative, and financial expertise necessary to conduct epidemiological studies of Indian communities.

‘‘(B) assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

‘‘(c) Technical Assistance.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

‘‘(d) Grants.—In general.—

‘‘(1) IN GENERAL.—The Secretary may make grants to Indian tribes, tribal organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

‘‘(2) Eligible Intertribal Consortia.—An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium—

‘‘(A) incorporated for the primary purpose of improving Indian health; and

‘‘(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

‘‘(3) Applications.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary determines.

‘‘(4) Requirements.—An applicant for a grant under this subsection shall—

‘‘(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

‘‘(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

‘‘(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

‘‘(5) Use of Funds.—A grant provided under paragraph (1) may be used—

‘‘(A) to carry out the functions described in subsection (b);

‘‘(B) to provide information to, and consult with, tribal leaders, urban Indian community leaders, and related health staff regarding health care and health service management issues; and

‘‘(C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.

‘‘(e) Access to Information.—

‘‘(1) IN GENERAL.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a research or to carry out the functions described in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 1936).

‘‘(2) Access to Information.—The Secretary shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

‘‘(f) Quentin N. Burdick Program Grant.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the ‘Quentin N. Burdick American Indians Into Psychology Program’. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian health programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program funded under section 115(e), and existing university research and communications networks.

‘‘(g) Regulations.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

‘‘(h) Conditions of Grant.—Applicants under this section shall agree to provide a program which, at a minimum—

‘‘(1) provides outreach and recruitment for health professions to Indian communities in-cludes elementary, secondary, and accredited and accessible community colleges that will be served by the program;

‘‘(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

‘‘(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

‘‘(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

‘‘(5) develops affiliation agreements with tribal colleges and universities, the Service, and other appropriate accredited and accessible entities to enhance the education of Indian students;
‘(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

‘(7) to the maximum extent feasible, employs the services of the Indian Health Service.

‘(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 113 of the Indian Health Care Improvement Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

‘(1) in an Indian health program;

‘(2) in a program assisted under title V; or

‘(3) in a program of a private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

‘(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for fiscal year 2010 and each fiscal year thereafter.’.’

SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

Section 218 of the Indian Health Care Improvement Act (25 U.S.C. 1621q) is amended to read as follows:

‘SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

‘(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian tribes and tribal organizations for the following:

‘(1) education programs for the prevention, control, and elimination of communicable and infectious diseases;

‘(2) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. pylori;

‘(3) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases;

‘(4) education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

‘(b) APPLICATION REQUIRED.—The Secretary may provide grants under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

‘(c) COORDINATION WITH HEALTH AGENCIES.—Indian tribes and tribal organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

‘(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

‘(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

‘(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.

SEC. 134. METHODS TO INCREASE CLINICIANS RECRUITMENT AND RETENTION.

(a) LICENSING.—Section 221 of the Indian Health Care Improvement Act (25 U.S.C. 1621t) is amended to read as follows:

‘SEC. 221. LICENSING.

‘(a) LICENSING.—Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under this title or the Indian Health Care Improvement Act of 1990, as amended, and the Indian Health Care Improvement Act of 1990, as amended, and the Indian Health Care Improvement Act of 1994, as amended, and the Indian Health Care Improvement Act of 1996, as amended.

‘(b) TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.—A scholarship provided to an individual pursuant to this title shall be considered to be a qualified scholarship for the purpose of section 117 of the Internal Revenue Code of 1986.

‘(c) CONTINUING EDUCATION ALLOWANCES.—Section 106 of the Indian Health Care Improvement Act (25 U.S.C. 1615) is amended to read as follows:

‘SEC. 106. CONTINUING EDUCATION ALLOWANCES.

‘In order to encourage scholarship and stipend recipients under sections 104, 105, and 115 and health professionals, including community health workers and emergency medical technicians, to join or continue in an Indian health program and to provide services in the rural and remote areas in which a portion of Indians reside, the Secretary, acting through the Service, may—

‘(1) provide grants or allowances to transition into an Indian health program, including licensing, board or certification examination assistance, and technical assistance to facilitate obligations under sections 104, 105, and 115; and

‘(2) provide grants or allowances to health professionals employed in an Indian health program to enable those professionals to achieve the education necessary to become qualified by regulation of the Secretary, to take leave of the duties of the professionals for professional consultation, management, leadership, and refresher training courses.

SEC. 135. LIABILITY FOR PAYMENT.

Section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621a) is amended to read as follows:

‘SEC. 222. LIABILITY FOR PAYMENT.

‘(a) NO PATIENT LIABILITY.—A patient who receives services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

‘(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract care health services that such patient is not liable for the payment of any charges or costs associated with the provider of such services.

‘(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.

SEC. 136. OFFICE OF INDIAN MEN’S HEALTH AND INDIAN WOMEN’S HEALTH.

Section 223 of the Indian Health Care Improvement Act (25 U.S.C. 1621t) is amended to read as follows:

‘SEC. 223. OFFICES OF INDIAN MEN’S HEALTH AND INDIAN WOMEN’S HEALTH.

‘(a) OFFICE OF INDIAN MEN’S HEALTH.—

‘(1) ESTABLISHMENT.—The Secretary may establish within the Service an office to be known as the ‘Office of Indian Men’s Health’.

‘(2) DIRECTOR.—The Director of the Office of Indian Men’s Health shall be appointed by the Secretary.

‘(b) OFFICE OF INDIAN WOMEN’S HEALTH.—The Secretary, acting through the Service, shall establish an office, to be known as the ‘Office of Indian Women’s Health’, to work with the Service.

‘(c) OFFICE OF INDIAN WOMEN’S HEALTH.—The Secretary, acting through the Service, shall establish an office, to be known as the ‘Office of Indian Women’s Health’, to work with the Service.

SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621 et seq.) is amended by adding at the end the following:

‘SEC. 228. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

‘(a) SUBMISSION OF REPORT.—As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General of the United States shall submit to the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available for public inspection the results of the study of the Comptroller General regarding the funding of the contract health service program (including historical funding levels and a recommendation of the funding level needed for the program) and the administration of the contract health service program (including the distribution of funds pursuant to the program, as requested by Congress in March 2009, or pursuant to section 830).

‘(b) OFFICE OF INDIAN MENS HEALTH AND OFFICE OF INDIAN WOMENS HEALTH.—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program.

‘(1) to determine whether the current distribution formula would require modifications if the contract health service program were funded at the level recommended by the Comptroller General;

‘(2) to identify any inequities in the current distribution formula for fiscal years when the funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

‘(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program;

‘(4) to identify any other issues and recommendations to improve the administration of the contract health service program and correct any unfair results or funding distribution that the Comptroller General recommended in any program administration that may result in the inefficient or ineffective management of the program; and

‘(5) to consult with Indian tribes under subsection (b), the Secretary shall consult with Indian tribes under subsection (b), the Secretary shall consult with Indian tribes and the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program.

‘(c) SUBSEQUENT ACTION BY SECRETARY.—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b) exists, the Secretary may initiate procedures under subsection (c) of this section.”
SEC. 141. HEALTH CARE FACILITY PRIORITY SYSTEM.

Section 301 of the Indian Health Care Improvement Act (25 U.S.C. 1631) is amended—

(1) redesignating subsection (d) as subsection (h); and

(2) by striking subsection (c) and inserting the following:

"(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

"(1) In general.—

"(A) Establishment of system.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

"(i) shall be developed in consultation with Indian tribes and tribal organizations;

"(ii) shall give Indian tribes' needs the highest priority;

"(iii)(I) may include the lists required in paragraph (2)(B)(i); and

"(II) shall include the methodology required in paragraph (2)(B)(v); and

"(III) may include such health care facilities, and such renovation or expansion needs of any Indian tribe, as the Service may identify; and

"(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

"(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

"(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be included in the needs determined by the Secretary to the Secretary.

"(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in the 60 days of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

"(i) was identified in the fiscal year 2008 Service budget justification as—

"(I) 1 of the 10 top-priority inpatient projects;

"(II) 1 of the 10 top-priority outpatient projects;

"(III) 1 of the 10 top-priority staff quarters development; or

"(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

"(ii) in either Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

"(iii) is not included in clause (i) or (ii) and is selected by the Secretary—

"(I) on the initiative of the Secretary; or

"(II) pursuant to a request of an Indian tribe or tribal organization.

"(3) Of those terms are defined in subsection (a)."

"(D) FACILITIES APPROPRIATION ADVISORY BOARD.—The term ‘Facilities Appropriation Advisory Board’ means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director—

"(aa) to provide advice and recommendations for policies and procedures of the programs funds pursuant to facilities appropriations; and

"(bb) to address other facilities issues.

"(E) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term ‘Facilities Needs Assessment Workgroup’ means the workgroup established at the discretion of the Director—

"(aa) to review the health care facilities construction priority system; and

"(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

"(F) Initial report.—

"(1) In general.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Indian, Tribal, and Native American Affairs of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including Indian health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the ‘Facilities Needs Assessment Workgroup’ and the Facilities Appropriation Advisory Board.

"(2) Inclusions.—The initial report shall include—

"(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

"(bb) such other information as the Secretary determines to be appropriate.

"(G) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

"(1) update the report under clause (I) not less frequently than once every 5 years; and

"(2) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

"(H) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

"(1) A description of the health care facility priority system of the Service established under this section and the methodologies applied, and the processes for prioritizing facilities needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

"(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(1)); and

"(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or health centers.

"(2) Submission to Congress.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

"(I) the Committees on Indian Affairs and Appropriations of the Senate;

"(II) the Congress on Native Affairs and Appropriations of the House; and

"(III) the Secretary.

"(I) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) and sections 504 and 505 of that Act (25 U.S.C. 458aaa-3, 458aaa-5)."

"(J) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include—

"(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

"(2) approaches provided for in other provisions of this title; and

"(3) other approaches, as the Secretary determines to be appropriate.

SEC. 142. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

Section 307 of the Indian Health Care Improvement Act (25 U.S.C. 1637) is amended to read as follows:

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

"(a) PURPOSE AND GENERAL AUTHORITY.—

"(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary, acting through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.).—
‘(A) to test alternative means of delivering health care and services to Indians through facilities; or

‘(B) to use alternative or innovative methods of delivering health care services to Indians (including primary care services, contract health services, or any other program or service authorized by this Act) through demonstration projects (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share facilities, funding, or other resources, or otherwise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

‘(2) AUTHORITY.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

‘(A) test alternative means of delivering health care and services to Indians through facilities; or

‘(B) otherwise carry out the purposes of this section.

‘(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section—

‘(1) may authorize such contracts for the construction, renovation, or expansion of facilities, health centers, health stations, and other facilities to deliver health care services; and

‘(2) is authorized—

‘(A) to waive any leasing prohibition; and

‘(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health care delivery demonstration projects) to Indian tribes, a consortium of Indian tribes, or tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services in a Service area (or a portion of, or facility within, the Service area) as described in the application or request, including medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care service delivery models deemed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

‘(3) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (A).

‘(c) CRITERIA.—The Secretary shall approve under this paragraph demonstration projects that meet all of the following criteria:

‘(1) The criteria set forth in paragraph (2)(A).

‘(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at health care facilities or other factors.

‘(iii) The project—

‘(A) expands the availability of services; or

‘(B) reduces—

‘(aa) the burden on Contract Health Services; or

‘(bb) the need for emergency room visits.

‘(d) TECHNICAL ASSISTANCE.—On receipt of an application for a demonstration project, the Secretary shall provide technical assistance to the applicant, including assistance in the development or improvement of an existing facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

‘(e) SERVICE TO INELIGIBLE PERSONS.—Subject to section 813, the authority to provide services to persons otherwise ineligible for services under this Act, and to the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included in the terms of that section, in any demonstration project approved pursuant to this section.

‘(f) USE OF FUNDS.—The Secretary shall use the funds provided under this Act for the purposes of this section, including—

‘(i) the provision of health care services to persons enrolled in a health care delivery demonstration project; and

‘(ii) the provision of health care services to persons enrolled in a health care delivery demonstration project under a proposal approved under this section.

‘(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Serv-

Title III of the Indian Health Care Improvement Act (as amended by section 101(b) is amended by inserting after section 308 (25 U.S.C. 1638) the following:

‘SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

‘(a) RENTAL RATES.—In establishing rental rates under this subsection, a tribal health program shall—

‘(A) base the rental rates on the reasonable value of the quarters to the occupants of the quarters;

‘(B) to generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and at the discretion of the tribal health program, to supply reserve funds for capital repairs and replacement of the quarters.

‘(c) EQUITABLE FUNDING.—A federally owned quarters the rates which are established by a tribal health program under this subsection shall remain eligible to receive improvement and repair funds to the same extent that other owned quarters used to house personnel in programs of the Service are eligible to receive these funds.

‘(4) NOTICE OF RATE CHANGE.—A tribal health program that establishes a rental rateunder this subsection shall provide occupants of the federally owned quarters a notice of any change in the rental rate not later than the date that is 60 days notice before the effective date of the change.

‘(5) RATES IN ALASKA.—A rental rate established by a tribal health program for a federally owned quarters in the State of Alaska may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

‘(b) DIRECT COLLECTION OF RENT.—(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a tribal health program may collect rent directly from Federal employees living on Indian reservations. If the tribal health program submits to the Secretary and the employees a notice of the election of the tribal health program to collect rent directly from Federal employees living on Indian reservations, the provisions of paragraph (2) shall be inapplicable.
“(A) the affected Federal employees shall pay rent for occupancy of a federally owned quarters directly to the applicable tribal health program; and

“(B) the Secretary shall not have the authority to collect rent from the employees through payroll deduction or otherwise.

“(3) Use of payments.—The rent payments under paragraph (2) are:

“(A) shall be retained by the applicable tribal health program in a separate account, which shall be used by the tribal health program to maintain the maintenance (including capital repairs and replacement) and operation of the quarters, as the tribal health program determines appropriate; and

“(B) shall not be made payable to, or otherwise be deposited with, the United States.

“(4) Retroscession of Authority.—If a tribal health program that elected to collect rent directly under paragraph (1) requests retroscession of the authority of the tribal health program to collect that rent, the retroscession shall take effect on the earlier of—

“(A) the first day of the month that begins not less than 180 days after the tribal health program submits the request; and

“(B) as may be mutually agreed on by the Secretary and the tribal health program.”

SEC. 144. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following:

“SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

“(a) Authorization.—

“(1) AUTHORITY TO TRANSFER FUNDS.—The head of any Federal agency to which funds, equals, or other supplies from those entities, to provide grants for the planning, design, construction, or operation of a health care or sanitation facility to achieve—

“(1) off-site using prefabricated component units for subsequent transport to the designated location; and

“(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

“(b) Establishment.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for demonstration projects, including the evaluation of the success of the activity; and

“(c) Authorization of Appropriations.—There are authorized to be appropriated $50,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.

SEC. 145. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at section 144 is amended by adding at the end the following:

“SEC. 145. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

“(a) Definition of Modular Component Health Care Facility.—In this section, the term ‘modular component health care facility’ means a health care facility that is constructed—

“(1) off-site using prefabricated component units for subsequent transport to the designated location; and

“(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

“(b) Establishment.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for demonstration projects, including the evaluation of the success of the activity; and

“(c) Authorization of Appropriations.—There are authorized to be appropriated $50,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.

SEC. 146. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following:

“SEC. 146. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

“(a) Definitions.—In this section:

“(1) Eligible Tribal Consortium.—The term ‘eligible tribal consortium’ means a consortium composed of 2 or more Service units between which a mobile health station can be transported by road in up to 8 hours. A Service unit operated by the Service or by an Indian tribe or tribal organization shall be equally eligible for participation in such consortium.

“(2) Mobile Health Station.—The term ‘mobile health station’ means a health care unit that—

“(A) is constructed, maintained, and capable of being transported within a semi-trailer truck or similar vehicle;

“(B) is equipped for the provision of 1 or more specialty health care services; and

“(C) can be equipped to be docked to a stationary health care facility when appropriate.

“(3) Specialty Health Care Service.—

“(A) In General.—The term ‘specialty health care service’ means a health care service which requires the services of a health care professional with specialized knowledge or experience.

“(B) Inclusions.—The term ‘specialty health care service’ includes any service relating to—

“(i) dialysis;

“(ii) surgery;

“(iii) mammography;

“(iv) dentistry; or

“(v) any other specialty health care service.

“(c) Establishment.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall provide at least 3 mobile health station projects.

“(d) Petition.—To be eligible to receive a grant under this section, an Indian tribe or tribal organization must submit to the Secretary a petition to construct a modular component health care facility in the Indian tribe or tribal organization, at such time, in such manner, and containing such information as the Secretary may require.

“(e) Effect of Selection.—A modular component health care facility project selected for participation in the demonstration program shall not be eligible for entry on the facilities construction priorities list entitled ‘IHS Health Care Facilities FY 2011 Planned Construction Projects’ as of the date and entitled 2009, and on any successor list.

“(d) Eligibility.—

“(1) In General.—An Indian tribe may submit a petition under subsection (b) regarding the tribe's eligibility to participate in the demonstration program, the funds provided for the project shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 456 et seq.).

“(2) Administration.—At the election of an Indian tribe or tribal organization participating in the demonstration program, the funds provided for the project shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 456 et seq.).

“(e) Reports.—Not later than 1 year after the date on which funds are made available for demonstration projects, and annually thereafter, the Secretary shall submit to Congress a report describing—

“(1) each activity carried out under the demonstration program, including an evaluation of the success of the activity; and

“(2) the potential benefits of increased use of modular component health care facilities in other Indian communities.

“(f) Authorization of Appropriations.—

“THERE ARE AUTHORIZED TO BE APPROPRIATED $50,000 TO CARRY OUT THE DEMONSTRATION PROGRAM UNDER THIS SECTION FOR THE FIRST 5 FISCAL YEARS, AND SUCH SUMS AS MAY BE NECESSARY TO CARRY OUT THE PROGRAM IN SUBSEQUENT FISCAL YEARS.
“(3) such other information as the Secretary may require.

“(d) USE OF FUNDS.—The Secretary shall use amounts made available to carry out the demonstration program under this section—

“(1) to establish, purchase, lease, or maintain mobile health stations for the eligible tribal consortium selected for projects and—

“(2) to provide, through the mobile health station, such specialty health care services as the affected eligible tribal consortium determined to be necessary for the Indian population served;

“(3) to establish, purchase, or maintain docking equipment for a mobile health station, including the establishment or maintenance of such equipment at a modular component health care facility (as defined in section 312(a), if applicable).

“(e) REPORTS.—Not later than 1 year after the date the demonstration program is established under subsection (b) and annually thereafter, the Secretary, acting through the Service, shall submit to Congress a report describing—

“(1) each activity carried out under the demonstration program including an evaluation of the success of the activity; and

“(2) the potential benefits of increased use of mobile health stations to provide specialty health care services for Indian communities.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 per year to carry out the demonstration program for the first 5 fiscal years, and such sums as may be needed to carry out the program in subsequent fiscal years.”.

Subtitle D—Access to Health Services

SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

Section 401 of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended to read as follows:

“SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

“(a) DISHARE OR MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS RECEIVED BY AN INDIAN HEALTH PROGRAM or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

“(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XIX, X or XXI of the Social Security Act in preference to an Indian without such coverage.

“(c) USE OF FUNDS.—

“(1) SYNDROME PROGRAMS.—“(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), each payment to a facility [or amount receivable in such amounts provided in appropriation Acts] for the purpose of making any improvements in the programs of the Service operated by or on behalf of the Service, made in excess of the amount necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so receivable in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served through such facility which may be necessary to achieve or maintain such conditions and requirements, be used by the Service to purchase or lease such equipment as is necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so receivable in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served through such facility which may be necessary to achieve or maintain such conditions and requirements, be used (to such extent or in such amounts as may be deemed necessary to achieve or maintain compliance with such conditions and requirements) to purchase or lease such equipment as is necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title.

“(B) COORDINATION OF INFORMATION.—The Secretary of Health and Human Services shall work with the Service on a regular basis and in consultation with the Indian tribes served through such facility to collect and disseminate information concerning the health care needs of the Indian tribes served through such facility which are not otherwise available to the Service.

“(2) DIRECT BILLING.—

“(1) IN GENERAL.—Subject to the requirements of paragraph (2), a tribal health program may elect to directly bill, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

“(2) DIRECT REIMBURSEMENT.—

“(A) USE OF FUNDS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be used for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the applicable conditions and requirements generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities, other health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any noncontract Indian health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 302.

“(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to this Act and the audit requirements applicable to programs administered by an Indian health program.

“(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Such amounts shall be treated as a payment for a service or service within a contract health service delivery area that would otherwise be provided as a contract health service and shall not be deemed to be a direct bill as such term is defined by section 302.

“(D) REPORTS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report describing the amount of payments made to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act.

“(E) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1902, and 2107(e)(1)(D) of the Social Security Act.”.

SEC. 152. PURCHASING HEALTH CARE COVERAGE.

Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended to read as follows:

“SEC. 402. PURCHASING HEALTH CARE COVERAGE.

“(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of title VIII or XIX of the Social Security Act) to provide to an Indian with coverage under title XVIII, XIX, or XXI of the Social Security Act, payments may be made out of the special fund described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

“(b) DIRECT BILLING.—

“(1) IN GENERAL.—Subject to the requirements of paragraph (2), a tribal health program may elect to directly bill, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

“(2) DIRECT REIMBURSEMENT.—

“(A) USE OF FUNDS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be used for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the applicable conditions and requirements generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities, other health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any noncontract Indian health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 302.

“(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to this Act and the audit requirements applicable to programs administered by an Indian health program.

“(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Such amounts shall be treated as a payment for a service or service within a contract health service delivery area that would otherwise be provided as a contract health service and shall not be deemed to be a direct bill as such term is defined by section 302.

“(D) REPORTS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report describing the amount of payments made to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act.

“(E) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1902, and 2107(e)(1)(D) of the Social Security Act.”.
“(2) a State or locally authorized or li-
"censed health care plan; “
“(3) a health insurance provider or man-
geaged care organization; “
“(4) a self-insured trust; or “
“(5) a high deductible or health savings ac-
count plan.

(b) **FINANCIAL NEED.**—The purchase of
by the subchapter (a) by an Indian
obal, tribal organization, or urban Indian
organization may be based on the financial
in the case of such beneficiaries (as determined by
the 1 or more Indian
of health care items and services to Indians

(c) **EXPENSES FOR SELF-INSURED PLAN.**—In
the case of a self-insured plan under sub-
section (a)(4), the amounts may be used for
of operating the plan, including ad-
ministration and insurance to limit the fin-
cial risks to the entity offering the plan.

(d) **CONSTRUCTION.**—Nothing in this sec-
tion shall be construed as affecting the use
of any amounts not referred to in subsection
(a).

**SEC. 153. GRANTS TO AND CONTRACTS WITH THE
SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS,
AND URBAN INDIAN TRIBAL ORGANIZATIONS TO FACIL-
ITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER
SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER
HEALTH BENEFITS PROGRAMS.**

Section 404 of the Indian Health Care Im-
provement Act (25 U.S.C. 1644) is amended to
read as follows:

**SEC. 404. GRANTS TO AND CONTRACTS WITH THE
SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS,
AND URBAN INDIAN TRIBAL ORGANIZATIONS TO FACIL-
ITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER
SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER
HEALTH BENEFITS PROGRAMS.**

(1) **INDIAN TRIBES AND TRIBAL ORGANIZA-
TIONS.**—The Secretary, acting through the
Service, shall make grants to or enter into
contracts with Indian tribes and tribal orga-
nizations to assist such tribes and tribal orga-
nizations in establishing and admin-
istering programs on or near reservations
and trust lands, including programs to pro-
vide outreach and enrollment through video,
electronic media, and other commu-
nication devices that allow real-time or
time-delayed communication between in-
dividual Indians and the benefit program,
to assist individuals—

(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of
the Social Security Act and other health
benefits programs; and

(2) with respect to such programs for
which the charging of premiums and cost
sharing is not prohibited under such pro-
grams, to effect costs or cost sharing for
coverage for such benefits, which may be
based on financial need (as determined by
the Indian tribes, tribes or tribal organi-
nizations involved) or based on a schedule of in-
come levels developed or implemented by
such tribe, tribes, or tribal organizations.

(b) **COORDINATION WITH OTHER PROGRAMS.**
The Secretary, acting through the Service,
shall place conditions as deemed necessary to effect the purpose of
this section in any grant or contract which the Secretary makes with any Indian tribe or
tribal organization pursuant to this sec-
tion. Such conditions shall include require-
ments that the Indian tribe or tribal organi-
sation—

(1) to determine the population of Indians eligible for the benefits described in sub-
section (a);

(2) to educate Indians with respect to the benefits available under the respective pro-
grams;

(3) to provide transportation for such in-
dividual Indians to the appropriate offices
for enrollment or applications for such bene-
fits; and

(4) to develop and implement methods of
improving the participation of Indians in
receiving benefits under such programs.

(c) **APPLICATION TO URBAN INDIAN ORGANI-
ZATIONS.**

(1) **IN GENERAL.**—The provisions of sub-
section (a) shall apply with respect to grants and other funding to urban Indian organiza-
tions with respect to populations served by
such organizations in the same manner they
apply to grants and contracts with Indian
tribes and tribal organizations with respect
to programs for the case of the Service (or
the case may be) where services are provided
through the Service, an Indian tribe, or a
tribal organization to beneficiaries eligible
for coverage under such programs.

(2) **REQUIREMENTS.**—The Secretary shall
include in the grants or contracts made or
provided under paragraph (1) requirements that are—

(A) consistent with the requirements im-
posed by the Secretary under subsection (b);

(B) appropriate to urban Indian organiza-
tions and urban Indians; and

(C) necessary to effect the purposes of
this section.

(3) **FACILITATING COOPERATION.**—The Secre-
tary, acting through the Centers for Medi-
care & Medicaid Services, shall develop and
and disseminate best practices that will serve to
facilitate cooperation with, and agreements
between the Service, an Indian tribe, a
tribal organization, or urban Indian
organizations with respect to the provision
of health care items and services to Indians
under the programs established under title
XVIII, XIX, or XXI of the Social Security Act.

(4) **AGREEMENTS RELATING TO IMPROVING
ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY
ACT HEALTH BENEFITS PROGRAMS.**—For
provisions relating to agreements of the Secre-
tary, acting through the Service, for the
submission of applications by Indians for assistance
under the Medicaid and children's health insurance
programs established under titles XIX and
XXI of the Social Security Act, and benefits
under the Medicare program established under
title XVIII of such Act, see sub-
sections (a) and (b) of section 119 of the
Social Security Act.

(5) **DEFINITION OF PREMIUMS AND COST SHARING.**—In
this section—

(1) the term 'premium' includes any deduction, deductible, co-
payment, coinsurance, or similar charge;

(2) the term 'cost sharing' includes any deduction, deductible, co-
payment, coinsurance, or similar charge.

**SEC. 154. SHARING ARRANGEMENTS WITH FED-
ERAL AGENCIES.**

Section 405 of the Indian Health Care Im-
provement Act (25 U.S.C. 1645) is amended to
read as follows:

**SEC. 405. SHARING ARRANGEMENTS WITH FED-
ERAL AGENCIES.**

(1) **AUTHORITY.**—

(a) **IN GENERAL.**—The Secretary may enter
into (or expand) arrangements for the shar-
ing of medical facilities and services between the
Service, Indian tribes, and tribal organi-
zations and the Department of Veterans Af-
fairs and the Department of Defense.

(b) **CONSULTATION BY SECRETARY RE-
QUIRED.**—The Secretary may not finalize any
arrangement between the Service and a De-
partment described in paragraph (1) without
first consulting with the Indian tribes which will
be significantly affected by the arrange-
ment.

(c) **LIMITATIONS.**—The Secretary shall
not take any action under this section or under
subchapter IV of chapter 81 of title 38, United States
Code, with respect to

(1) the priority access of any Indian to
health care services provided through the
Service and the eligibility of any Indian to
receive health services through the Service;

(2) the quality of health care services pro-
vided to any Indian through the Service;

(3) the delay or priority access of any Indian
to health care services provided by the Depart-
ment of Veterans Affairs;

(4) the quality of health care services pro-
vided by the Department of Veterans Affairs or
the Department of Defense; or

(5) the eligibility of any Indian who is a
veteran to receive health services through the
Department of Veterans Affairs.

(2) **REIMBURSEMENT.**—The Service, Indian
tribe, or tribal organization shall be reim-
bursed by the Department of Veterans Af-
fairs for the provision of services (or the case
may be) where services are provided
through the Service, an Indian tribe, or a
tribal organization to beneficiaries eligible
for services from either such Department,
notwithstanding any other provision of law.

(3) **CONSTRUCTION.**—Nothing in this sec-
tion may be construed as creating any right
of a non-Indian veteran to obtain health
services from the Service.

**SEC. 155. ELIGIBLE INDIAN VETERAN SERVICES.**

Title IV of the Indian Health Care Im-
provement Act (29 U.S.C. 1191 et seq.)
(as amended by section 101(b)) is amended by
adding at the end the following:

**SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.**

(1) **FINDINGS.**—Congress finds that—

(A) collaborations between the Secretary
and the Secretary of Veterans Affairs regard-
ing the treatment of Indian veterans at fa-
cilities of the Service should be encouraged to the
maximum extent practicable; and

(B) increased enrollment for services of the
Department of Veterans Affairs for veterans
who are members of an Indian tribe or tribal
organization should be encouraged to the maximum
extent practicable.

(2) **PURPOSE.**—The purpose of this section
is to reaffirm the goals stated in the document
entitled ‘Memorandum of Under-
standing Between the VA/Veterans Health
Administration And HHS/Indian Health
Service’ and dated February 25, 2003 (relating
to cooperation and resource sharing between
the Veterans Health Administration and Service).

(b) **DEFINITIONS.**—In this section—

(1) **ELIGIBLE INDIAN VETERAN.**—The term
‘eligible Indian veteran’ means an Indian or
Alaska Native veteran who receives any
medical service that is—

(A) authorized under the laws adminis-
tered by the Secretary of Veterans Affairs; and

(B) administered at a facility of the Serv-
vice (including a facility operated by an
Indian tribe or tribal organization through a
contract or compact with the Service under
the Indian Self-Determination and Edu-
cation Assistance Act (25 U.S.C. 450 et seq.)
pursuant to a local memorandum of under-
standing.

(2) **LOCAL MEMORANDUM OF UNDER-
STANDING.**—The term ‘local memorandum of
understanding’ means a memorandum of un-
derstanding between the VA/Veterans Health
Administration and Indian Health Service.

(3) **ELIGIBLE INDIAN VETERANS EX-
PERIENCE.**

(1) **IN GENERAL.**—Notwithstanding any
other provision of law, the Secretary shall
provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

(2) METHOD OF PAYMENT.—The Secretary shall establish guidelines that require the Secretary to negotiate local memorandums of understanding with the Secretary of Veterans Affairs under paragraph (1).

(3) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement for services furnished under any such program for health care services furnished to an Indian.

(4) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' means the Indian Health Service, the Veterans Health Administration, or an Indian tribe or tribal organization under section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b), or, except that, for purposes of this subsection, such term shall include the health insurance program under title XXVI of the Social Security Act (42 U.S.C. 1320b-9(c)).

SEC. 157. ACCESS TO FEDERAL INSURANCE.

Title IV of the Indian Health Care Improvement Act (42 U.S.C. 150 et seq.) (as amended by section 156) is amended by adding at the end the following:

"(d) FUNDING.—For purposes related to nondiscrimination against providers operated by the Indian tribe, tribal organization, or urban Indian organization that is an Indian tribe or an urban Indian organization under section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b), or the Secretary shall provide funds for the purpose of—

"(1) providing assistance to the Indian tribe or an urban Indian organization that is an Indian tribe or an urban Indian organization to provide health care services to an Indian.

"(2) providing assistance to the Navajo Nation as a State for the purpose of improving the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act; and

"(3) providing an appropriate level of matching funds for assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

"(4) authorizing, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children’s health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

"(c) REPORT.—Not later than 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

"(1) the results of the study under this section;

"(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties currently paid to or would otherwise be paid by the Secretary for the provision of services and related administrative costs under this title; and

"(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

"(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

Subtitle E—Health Services for Urban Indians

SEC. 161. FACILITIES RENOVATION.

Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659) is amended by inserting ‘‘or construction or expansion of facilities under any ‘‘rehabilitation’’’.

SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

Section 512 of the Indian Health Care Improvement Act (25 U.S.C. 1660b) is amended by adding to read as follows:

"(d) AUTHORIZATION OF APPROPRIATIONS.—Notwithstanding any other provision of law, the Tusla Clinic and Oklahoma City Clinic demonstration projects shall—

"(1) be considered within the Service’s direct care program;

"(2) continue to be treated as Service units and operating units in the allocation of resources and coordination of care; and

"(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

SEC. 163. REQUIREMENT TO CONFERENCE WITH URBAN INDIAN ORGANIZATIONS.

(a) CONFERENCE WITH URBAN INDIAN ORGANIZATIONS.—Title V of the Indian Health Care Improvement Act (25 U.S.C. 1653 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:
"SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—Pursuant to the Act of November 2, 2001 (25 U.S.C. 218, 702, and 708(g).''.

(b) CONDITIONS.—Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) is amended by adding at the end the following:

"SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Notwithstanding any other provision of this Act, the Secretary, acting through the Service, is authorized to establish programs, including programs for awarding grants, for urban Indian organizations that are identical to any programs established pursuant to sections 218, 702, and 708(g)."

SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) is amended by adding at the end the following:

"SEC. 516. COMMUNITY HEALTH REPRESENTATIVES.

The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health care providers through the Community Health Representatives Program under section 107 in the provision of health care, health promotion, and disease prevention services to urban Indians.

SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY; HEALTH INFORMATION TECHNOLOGY.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) is amended by adding at the end the following:

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out the contract or grant, to use, in accordance with such terms and conditions for use and maintenance as are agreed on by the Secretary and the urban Indian organization,

(1) any existing facility under the jurisdiction of the Secretary;

(2) all equipment contained in or pertaining to such an existing facility; and

(3) any grant the Secretary makes to an urban Indian organization under the jurisdiction of the Federal Government under the jurisdiction of the Secretary.

(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined by the Secretary to be the property of the Service or the General Services Administration for the purposes of carrying out the contract or grant.

(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus personal or real property of the Federal Government for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for purposes of the contract or grant.

(d) PRIORITY.—If the Secretary receives a request for donation of an Indian tribe or tribal organization a request for a specific item of personal or real property described in subsection (b) or (c), the Secretary shall make the request for donation to the Indian tribe or tribal organization, if the Secretary receives the request from the Indian tribe or tribal organization before the expiration of:

(1) the date on which the Secretary transfers title to the property to the urban Indian organization; and

(2) the date on which the Secretary transfers the property physically to the urban Indian organization.

(e) EXECUTIVE AGENCY STATUS.—For purposes of section 40, United States Code, an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be considered to be an Executive agency in carrying out the contract or grant.

SEC. 518. HEALTH INFORMATION TECHNOLOGY.

The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 291 et seq.)) and other related infrastructure.

Subtitle F—Organizational Improvements

SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended to read as follows:

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended to read as follows:

(1) IN GENERAL.—In order to more efficiently and effectively carry out the responsibilities, authorities, and functions of the United States Government under this Act to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

(2) DIRECTOR.—The Service shall be administered by a Director, who shall be appointed by and with the advice and consent of the Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President and the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

(3) INCUMBENT.—The individual serving in the position of the Director of the Service on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall serve as Director.

(4) AUTHORITY.—By and with the advice of the Senate, the Secretary, acting through the Director, shall have the authority—
SEC. 604. NEVADA AREA OFFICE.

"Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) is amended to read as follows:

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS.

"Subtitle A—General Programs

"SEC. 701. DEFINITIONS.

"In this subtitle:

"(1) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS, ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system abnormalities, which may range from minor intellectual deficits and developmental delays to mental retardation. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other signs are not present in ARND, thus making diagnosis difficult.

"(2) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

"(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

"(4) Dual diagnosis.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill for the following:

"(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

"(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects, such as those resulting from alcohol consumption during pregnancy, by the mother during pregnancy, in- cluding suicide, child abuse, and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, and behavioral health programs.

"(B) To provide information, direction, and guidance relating to mental illness and dys- function and self-destructive behavior, inc luding child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, and behavioral health programs.

"(6) MODIFICATION OF EXISTING PROGRAMS AND AUTHORITIES.—The provisions of this subtitle shall be deemed to modify existing programs and authorities in the following:

"(7) RESTORATION.—The operations funds withheld pursuant to paragraph (2) may be restored, at the discretion of the Secretary, to the Office of the Director on achievement by that Office of compliance with this section.

"SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.

"(a) Establishment.—There is established within the Service an office, to be known as the 'Office of Direct Service Tribes'.

"(b) Treatment.—The Office of Direct Service Tribes shall be located in the Office of the Director.

"(c) Duties.—The Office of Direct Service Tribes shall be responsible for—

"(1) providing Service-wide leadership, guidance and support for direct service tribes to include strategic planning and program evaluation;

"(2) ensuring maximum flexibility to tribal health and related support systems for Indian beneficiaries;

"(3) serving as the focal point for consultation and participation between direct service tribes and organizations and the Service in the development of policy; and

"(4) directing a national program and providing leadership and advocacy in the development of health policy, program management, budget formulation, resource allocation, and delegation support for direct service tribes.

"SEC. 701. NEVADA AREA OFFICE.

"(a) General.—Not later than 1 year after the date of enactment of this section, in a manner consistent with the tribal consultation policy of the Service, the Secretary shall submit to Congress a plan describing the manner and schedule by which Indian tribes and tribal organizations are to participate in developing area-wide plans for Indian tribes and tribal organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

"(1) TITLE VII—BEHAVIORAL HEALTH

"(d) DEFINITIONS.—The term 'alcohol-related spectrum disorders' may include—

"(i) fetal alcohol syndrome (FAS);

"(ii) partial fetal alcohol syndrome (partial FAS);

"(iii) alcohol-related birth defects (ARBD); and

"(iv) alcohol-related neurodevelopmental disorders (ARND).

"(f) FAS OR FETAL ALCOHOL SYNDROME.—

"The term 'FAS or fetal alcohol syndrome' includes a range of effects, such as those resulting from alcohol consumption during pregnancy, by the mother during pregnancy, including malformations of the nervous system, including microcephaly, and facial anomalies. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other signs are not present in ARND, thus making diagnosis difficult.

"(1) To authorize and direct the Secretary, acting through the Service, Indian tribes, and tribal organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

"(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, and behavioral health programs.

"(3) To assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

"(4) To provide authority and opportunities for Indian tribes and tribal organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

"(5) To ensure that Indian tribes receive the services of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

"(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(7) PLANS.—

"(A) DEVELOPMENT.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

"(1) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence among Indian tribes, including—

"(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

"(ii) an estimate of the financial and human cost attributable to such illness or behavior.
“(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward eliminating the probability of the full continuum of care described in subsection (C).

“(C) An estimate of the additional funding needed by the Service, Indian tribes, tribal organizations, and urban Indian organizations to meet their responsibilities under the plans.

“(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include the clearinghouse established pursuant to this Act, and reports on the outcomes of such plans developed by Indian tribes, tribal organizations, urban Indian organizations, and Service areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian tribe, tribal organization, urban Indian organization, or the Service.

“(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the preparation of plans under this section and with respect to the referral and treatment of individuals with mental illness or drug addiction, or both.

“(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

“(1) COMMUNITY BEHAVIORAL HEALTH PLAN.—A comprehensive continuum of behavioral health care which provides—

“(A) community-based prevention, intervention, treatment, and aftercare; or

“(B) detoxification (social and medical);

“(C) acute hospitalization;

“(D) inpatient treatment;

“(E) residential treatment;

“(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

“(G) emergency shelter;

“(H) intensive case management;

“(1) diagnostic services; and

“(j) promotion of healthy approaches to risk and safety issues, including injury prevention.

“(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

“(A) preschool and school age fetal alcohol spectrum disorder services, including assessment and intervention;

“(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

“(C) identification and treatment of co-occurring disorders and comorbidity;

“(D) prevention of alcohol, drug, inhalant, and tobacco use;

“(E) early intervention, treatment, and aftercare;

“(F) promotion of healthy approaches to risk and safety issues; and

“(G) identification and treatment of neglect and physical, mental, and sexual abuse.

“(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco), including sex specific services;

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches for risk-related behavior; and

“(E) treatment services for women at risk of giving birth to a child with a fetal alcohol spectrum disorder; and

“(F) sex specific treatment for sexual assault and domestic violence.

“(4) FAMILY CARE.—Behavioral health services for families, including—

“(A) early intervention, treatment, and aftercare;

“(B) treatment for sexual assault and domestic violence; and

“(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

“(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches to managing conditions related to aging;

“(E) sex specific treatment for sexual assault, domestic violence, neglect, physical abuse, and sexual abuse and exploitation; and

“(F) identification and treatment of dementia regardless of cause.

“(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

“(1) ESTABLISHMENT.—The governing body of any Indian tribe, tribal organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan shall include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

“(2) TECHNICAL ASSISTANCE.—At the request of an Indian tribe, tribal organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization in the development and implementation of such plan.

“(3) FUNDING.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may make funding available to Indian tribes and tribal organizations which adopt such a plan in accordance with paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

“(e) COMMUNITY BEHAVIORAL HEALTH PLAN.—

“(1) the determination of the scope of the problem of alcohol and substance abuse

“(a) CONTENTS.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or renew and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.), to cooperate fully with the Service, including—

“(A) tribal coalitions, including interagency coalitions, intertribal coalitions, and tribal organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.));

“(B) the Department of Health and Human Services; and

“(C) the Department of the Interior.

“(b) PURPOSE.—The purpose of this memorandum of agreement is to—

“(1) enhance the availability of services to Indian communities that include programs and services that are consistent with the Department of the Interior’s strategic priorities and programs developed under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.);

“(2) provide for—

“(A) coordination of behavioral health services to which all citizens have access; and

“(B) coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

“(A) the coordination of alcohol and substance abuse programs by the Service, the Bureau of Indian Affairs and tribal organizations, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary treatment teams), at the central, area, and agency and Service unit, Service area, and headquarters levels to address the problems identified in paragraph (1); and

“(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

“(3) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly in the area of Service and Service unit levels, to cooperate fully with tribal requests pursuant to subsection (a) to improve the availability and accessibility of Indian health care facilities which can meet such need. In making such assessment, the Secretary shall consider the feasibility of existing, underused Service hospital beds into psychiatric units to meet such need.

“(d) REQUISITE.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Secretary shall assume responsibility for—

“(1) the determination of the scope of the problem of alcohol and substance abuse
among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human consequences;

“(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

“(3) an estimate of the funding necessary to adequately support a program of prevention and intervention and treatment of Indians affected by alcohol and substance abuse.

“(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian tribe, tribal organization, and urban Indian organization.

“SEC. 704. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include inpatient and appropriate, systems of care, and shall include—

“(A) prevention, through educational intervention, in Indian communities;

“(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

“(C) community-based rehabilitation and aftercare services to eligible and appropriate, systems of care, and shall include—

“(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

“(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

“(F) diagnostic services.

“(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian tribes, tribal organizations, and urban Indian organizations to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

“(b) CONTRACT HEALTH SERVICES.—

“(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

“(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

“SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.

“(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary shall establish and maintain a mental health technician program within the Service which—

“(1) provides for the training of Indians as mental health technicians; and

“(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, and treatment services.

“(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practice experience in the provision of such care.

“(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall provide for the evaluation of the mental health technicians in the training program.

“(d) TRADITIONAL HEALTH CARE PRACTITIONERS.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this section involves the use and promotion of the traditional health care practices of the Indian tribes to be served.

“SEC. 706. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

“(a) IN GENERAL.—Subject to section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

“(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

“(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

“(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

“(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

“SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.

“(a) GRANTS.—The Secretary, consistent with section 702, may make grants to Indian tribes, tribal organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations to develop and implement prevention, intervention, treatment, and rehabilitation for women and children born affected by exposure to alcohol and other substances.

“(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used—

“(1) to develop and provide community mental health education and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol spectrum disorders;

“(2) to identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

“(3) to develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

“(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

“(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—20 percent of the funds available for funding under this section shall be used to make grants to urban Indian organizations.

“SEC. 708. INDIAN YOUTH PROGRAM.

“(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 702, shall develop and carry out a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include inpatient and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations to include inpatient and rehabilitation facilities.

“(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

“(B) USE OF OFFICE IN CALIFORNIA.—For the purposes of this section, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

“(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding under this section may be used to make grants to the Act of November 2, 1921 (25 U.S.C. 13).

“(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian tribes to be served by such center.

“(4) SPECIFIC PROVISION OF FUNDS.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may make allocations to urban Indian organizations as appro priated for the purposes of carrying out this section, make funds available to—

“(i) the Tanana Chiefs Conference, Incorpor tion; for the purpose of carrying out the act of November 2, 1921 (25 U.S.C. 440b(i)).

“(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are constructed, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

“(C) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

“(1) IN GENERAL.—The Secretary, acting through the Service, shall provide intermediate behavioral health services, which may, if feasible and appropriate, incorporate systems of care, to Indian children and adolescents, including—

“(A) pretreatment assistance;

“(B) inpatient, outpatient, and aftercare services;

“(C) emergency care;

“(D) suicide prevention and crisis intervention; and
(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) USE OF FUNDS.—Funds provided under this subsection may be used—

(A) to construct or renovate an existing health facility to provide intermediate behavioral health care;

(B) to hire behavioral health professionals;

(C) to staff, operate, and maintain an intermediate behavioral health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

(E) for intensive home- and community-based services.

(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

(4) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

(e) REHABILITATION AND AFTERCARE SERVICES.

(1) IN GENERAL.—The Secretary, Indian tribes, or tribal organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service unit, a comprehensive rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community support, and monitoring, to support the Indian youths after their return to their home community.

(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and non-alcohol or substance abuse behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and para-professionals, including community health representatives.

(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out this paragraph shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 702, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and, to the extent appropriate, tobacco, consistent in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence, sequelae, and consequences of alcohol, drug, and inhalant abuse.

(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

(1) the number of Indian youth who are being provided mental health services through the Service and tribal health programs;

(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and tribal health programs;

(3) the number of youth referred to the Service or tribal health programs for mental health services;

(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and tribal health programs separately, and on- and off-reservation facilities; and

(5) the costs of the services described in paragraph (4).

SEC. 708. IDENTIFICATION AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 area offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

"(b) CRITERIA.—The Secretary shall establish criteria to determine which Indian Service area will be considered to have the greatest need for these services. The criteria shall include—

(1) the elevated risk of alcohol abuse and other behavioral health problems faced by the children of alcoholics;

(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating any other application or proposal for such funding, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"(d) AWARDS; CURRUMBA.—The Secretary may award a grant for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria—

(1) the project will address significant unmet behavioral health needs among Indians;

(2) the project will serve a significant number of Indians;

(3) the project has the potential to deliver services in an efficient and effective manner; and

(4) the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

"(e) The project may deliver services in a manner consistent with traditional health care practices.

"(f) The Secretary may coordinate, with and avoid duplication of, existing services.

"(g) The project is coordinated with, and avoids duplication of, existing services.

"(h) The project is coordinated with, and avoids duplication of, existing services.

"(i) The project is coordinated with, and avoids duplication of, existing services.

"(j) The project is coordinated with, and avoids duplication of, existing services.
“(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-affected Indian children.

“(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

“(vi) To develop, and disseminate education and prevention materials on fetal alcohol spectrum disorders.

“(vii) To develop and implement, in consultation with Indian tribes and tribal organizations, and in conference with urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers.

“(viii) To develop and provide training on fetal alcohol spectrum disorders to professionals providing services to Indians, including medical and allied health practitioners, social service providers, educators, and law enforcement, court officials and corrections personnel in the juvenile and criminal justice systems.

“(ix) Conclusions for—

“(1) Criteria for applications.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

“(I) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol spectrum disorders among Indians.

“(II) Community-based support services for Indian women and families with Indian children.

“(III) Community-based housing for adult Indians with fetal alcohol spectrum disorders.

“(3) Use of funds.—Funding provided pursuant to this section shall be used for the following:

“(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

“(2) To identify and provide behavioral health and sexual abuse training and education for those who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

“(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

“(4) To implement culturally sensitive assessment and diagnostic tools for use in Indian communities and urban centers.

“(c) Coordination.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

“SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

“(a) In general.—The Secretary, in accordance with section 702, is authorized to establish in each State and area programs involving the prevention and treatment of—

“(1) Indian victims of domestic violence or sexual abuse; and

“(2) other members of the household or family of the victims described in paragraph (1).

“(b) Use of funds.—Funds made available to carry out this section shall be used—

“(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

“(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

“(3) to purchase rape kits; and

“(4) to develop prevention and intervention models, which may incorporate traditional health care practices.

“(c) Training and certification.—

“(1) In general.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

“(2) Report.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

“(d) Coordination.—

“(1) In general.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual abuse victim organizations, shall develop appropriate victim services and victim advocate training programs—

“(A) to improve domestic violence or sexual abuse responses; and

“(B) to improve forensic examinations and collection;

“(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

“(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

“(2) Report.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the implementation and modeled problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

“SEC. 715. BEHAVIORAL HEALTH RESEARCH.

“(a) In general.—The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate organizations for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes, or tribal organizations among Indians in urban areas. Research priorities under this section shall include—

“(1) the multifactorial causes of Indian youth suicide, including—

“(A) protective and risk factors and scientific data that identifies those factors; and

“(B) the effects of loss of cultural identity and the development of scientific data on those effects;

“(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

“(3) the development of models of prevention techniques.

“(b) Emphasis.—The effect of the interrelationships and interdependencies referred to in subsection (a)(2) on children, and the development of prevention techniques under subsection (a)(3) applicable to children, shall be emphasized.

“Subtitle B—Indian Youth Suicide Prevention

“SEC. 721. FINDINGS AND PURPOSE.

“(a) Findings.—Congress finds that—

“(1)(A) the rate of suicide of American Indian and Alaska Native youth aged 15 through 24 is 1.9 times higher than the national average rate; and

“(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is 3.5 times the national average rate; and

“(ii) the highest rate of any population group in the United States; and

“(iii) other risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

“(A) history of previous suicide attempts;

“(B) family history of suicide;

“(C) history of depression or other mental illness;

“(D) alcohol or drug abuse;

“(E) health disparities;

“(F) stressful life events and losses;

“(G) easy access to lethal methods;

“(H) exposure to the suicidal behavior of others;

“(I) isolation; and

“(J) incarceration;

“(a) According to national data for 2005, suicide was the second leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;
December 4, 2009

CONGRESSIONAL RECORD — SENATE

S12453

"(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

"(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

"(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

"(B) demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

"(5)(A) Indian tribes, especially Indian tribes residing in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

"(B) the Indian country affects entire tribal communities;

"(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

"(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

"(B) all teens or all persons who die by suicide suffer from a diagnosable mental illness at time of death;

"(C) more than ½ of teens who die by suicide had never been seen by a mental health provider; and

"(D) ½ of health needs in Indian country relate to mental health;

"(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

"(9) the Substance Abuse and Mental Health Services Administration and the Service have demonstrated specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

"(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

"(A) the Substance Abuse and Mental Health Services Administration;

"(B) the Service;

"(C) the Centers for Disease Control and Prevention;

"(D) the National Institutes of Health; and

"(E) the Health Resources and Services Administration; and

"(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

(b) PURPOSES.—The purposes of this subtitle are—

"(1) to authorize the Secretary to carry out a demonstration project to test the use of telehealth services to suicide prevention, intervention, and treatment of Indian youth, including—

"(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

"(B) the provision of clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(C) training and related support for community leaders, family members, and health education workers who work with Indian youth;

"(D) the development of culturally relevant educational materials on suicide; and

"(E) data collection and reporting;

"(2) to encourage Indian tribes, tribal organizations, and health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and

"(3) to develop and distribute culturally appropriate community educational materials regarding—

"(i) suicide prevention;

"(ii) suicide education;

"(iii) suicide screening;

"(iv) suicide intervention; and

"(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

"(c) GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants under section (a) for the provision of telehealth services to Indian youth receiving telehealth services through the demonstration project.

"(2) ELIGIBILITY FOR GRANTS.—Grants under paragraph (1) shall be awarded to Indian tribes and tribal organizations that operate 1 or more facilities—

"(A) located in an area with documented disproportionately high rates of suicide;

"(B) reporting active clinical telehealth capabilities; or

"(C) offering school-based telemental health services to Indian youth.

"(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

"(4) MAXIMUM NUMBER OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian tribes and tribal organizations that—

"(A) serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide;

"(B) enter into collaborative partnerships with Service or other tribal health programs or facilities to provide services under this demonstration project;

"(C) serve an isolated community or geographic area with no access to behavioral health services; or

"(D) operate a detention facility at which Indian youth are detained.

"(5) CONSULTATION WITH ADMINISTRATION.—

"In developing and carrying out the demonstration project under this subsection, the Secretary shall consult with the Administration as the Federal agency focused on mental health issues, including suicide.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—An Indian tribe or tribal organization receiving a grant under subsection (a) for the following purposes:

"(A) To provide telemental health services to Indian youth, including the provision of—

"(i) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

"(iii) alcohol and substance abuse treatment.

"(B) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(C) To assist, educate, and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under the demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among those individuals and with State and local health services providers.

"(D) To conduct data collection and reporting relating to Indian youth suicide prevention efforts.

"(E) To develop and distribute culturally appropriate community educational materials regarding—

"(i) suicide prevention;

"(ii) suicide education;

"(iii) suicide screening;

"(iv) suicide intervention; and

"(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

"(F) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(G) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(H) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(I) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(J) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(K) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;

"(L) To provide clinical expertise to, consultation with, and medical advice and training for frontline health care providers working with Indian youth;
“(d) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian tribes and tribal organizations receiving grants under this section to collaborate to enable the Service and the Service's grantees to undertake the processes described in paragraphs (3) and (4) of subsection (a) of this section, including processes described in paragraphs (3) and (4) of subsection (a) of this section, to the extent feasible consistent with the needs of the Service and of Indian tribes and tribal organizations receiving grants under this section.

“(e) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

“(1) describes the number of telemental health services provided; and

“(2) includes any other information that the Secretary may require.

“(f) REPORTS TO CONGRESS.—

“(1) INITIAL REPORT.—Not later than 2 years after the date on which the final report is submitted under subsection (g) and ending on the date on which the final report is submitted under paragraph (h), the Secretary shall submit to the Committee on Indian Affairs and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that—

“(i) describes each project funded by a grant under this section during the preceding 2-year period, including a description of the level of success achieved by the project; and

“(ii) evaluates whether the demonstration project should be continued during the period beginning on the date of termination of funding for the demonstration project under subsection (g) and ending on the date on which the final report is submitted under paragraph (h).

“(2) CONTINUATION OF DEMONSTRATION PROJECT.—On a determination by the Secretary under clause (i) of subparagraph (A) that the demonstration project should be continued, the Secretary may carry out the demonstration project during the period described in that clause using such sums otherwise made available to the Secretary as the Secretary deems appropriate.

“(3) CLOSURE.—Not later than 270 days after the date of termination of funding for the demonstration project under subsection (g), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the Senate appropriate information on the demonstrations described in subsection (g) and the Secretary shall submit to the Committee on Indian Affairs of the House of Representatives a final report that—

“(A) describes the results of the projects funded under this section, including any data available that indicate the number of attempted suicides;

“(B) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

“(C) evaluates whether the demonstration project should be—

“(i) expanded to provide more than 5 grants; and

“(ii) designated as a permanent program; and

“(D) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

“(g) VETERO SERVICING OF APPROPRIATIONS.—

There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2010 through 2013.

“(h) REPEAL.—Sec. 723. USE OF PREDODUCTORY PSYCHOLOGY AND PSYCHIATRY INTERNs.

“(a) PURPOSE.—The purpose of this section is to authorize the Secretary, acting through

“(1) to increase the quantity of patients served by the Indian tribes, tribal organizations, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns; and

“(2) for purposes of recruitment and retention.

“(b) GRANT APPLICATION.—

There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2010 through 2013.

“(c) REPEAL.—Sec. 732A. FUNDING FOR YOUTH MENTAL HEALTH SERVICES AND THE NATIONAL CENTER FOR YOUTH MENTAL HEALTH SERVICES.

“(a) PURPOSE.—The purpose of this section is to authorize the Secretary, acting through
the Administration, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide, including through—

(1) the establishment of tribal partnerships to develop and implement such a curriculum in coordination with—

(A) behavioral health professionals, with a priority for tribal partnerships cooperating with mental health professionals employed by the Indian Health Service;

(B) tribal or local school agencies; and

(C) parent and community groups;

(2) the provision by the Administration or the Secretary of—

(A) technical expertise; and

(B) clinicians, analysts, and educators, as appropriate;

(3) training for teachers, school administrators, and community members to implement the curriculum;

(4) the establishment of advisory councils composed of parents, educators, community members, trained peers, and others to provide advice regarding the curriculum and other components of the demonstration program;

(5) the development of culturally appropriate support measures to supplement the effectiveness of the curriculum; and

(6) projects modeled after evidence-based projects, such as programs evaluated and published in relevant literature.

(b) Demonstration Grant Program.—

(1) Curriculum.—The term ‘curriculum’ means the culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide identified by the Secretary under paragraph (2)(A).

(2) Eligible Entity.—The term ‘eligible entity’ means—

(i) an Indian tribe;

(ii) a tribal organization;

(iii) any other tribally authorized entity; and

(iv) any partnership composed of 2 or more entities described in clause (i), (ii), or (iii).

(3) Establishment.—The Secretary, acting through the Administration, may establish and carry out a demonstration program under which the Secretary shall—

(A) identify the Indian tribes that are at greatest risk for adolescent suicide;

(B) identify the Indian tribes that are at greatest risk for adolescent suicide;

(C) invite those Indian tribes to participate in the demonstration program by—

(i) responding to a comprehensive program request of the Secretary;

(ii) submitting, through an eligible entity, an application in accordance with paragraph (4); and

(iii) providing grants to the Indian tribes identified under subparagraph (B) and eligible entities to implement the curriculum with respect to Indian and Alaska Native youths who—

(I) are between the ages of 10 and 19; and

(II) attend school in a region that is at risk of high youth suicide rates, as determined by the Administration.

(D) REQUIREMENTS.—

(A) Term.—The term of a grant provided under the demonstration program under this section shall be not less than 4 years.

(B) Maximum Number.—The Secretary may provide not more than 5 grants under the demonstration program under this section.

(2) Demonstration Grant Program.—

(a) In General.—The term of a grant provided under this section shall ensure that not less than 1 demonstration program shall be carried out at each of—

(i) a school operated by the Bureau of Indian Education;

(ii) a Tribal school; and

(iii) a school receiving payments under section 8002 or 8003 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7702, 7703).

(b) Applications.—To be eligible to receive a grant under the demonstration program, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

(A) an assurance that, in implementing the curriculum, the eligible entity will collaborate with 1 or more local educational agencies, including elementary schools, middle schools, and high schools;

(B) an assurance that the eligible entity will collaborate, for the purpose of curriculum development, implementation, and training and technical assistance, with 1 or more—

(i) nonprofit entities with demonstrated expertise and professional development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher or counselor not less frequently than twice each school week for the duration of the academic year;

(D) a description of the methods by which curriculum participants will be—

(i) screened for mental health at-risk indicators; and

(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis responsiveness; and

(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

(i) drug or alcohol abuse;

(ii) sexual or domestic abuse; and

(iii) depression and other relevant mental health concerns.

(3) Use of Funds.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may grant provided under this subsection—

(A) to develop and implement the curriculum in a school-based setting;

(B) to establish an advisory council—

(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

(C) to appoint and train a school- and community-based suicide prevention resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school administrators, and the advisory council established by the Indian tribe or eligible entity;

(D) to establish an on-site, school-based, MA- or PhD-level mental health practitioner (employed or available) to work with tribal educators and other personnel; and

(E) to provide for the training of peer counselors to assist in carrying out the curriculum;

(F) to procure technical and training support from nonprofit or State entities or other appropriate entities to ensure the success of the demonstration program; and

(G) to train teachers and school administrators to effectively carry out the curriculum;

(H) to establish an effective referral procedure and network—

(i) to identify and develop culturally compatible curriculum support measures; and

(ii) to obtain education and training purposes and other other resources from the Administration or other appropriate entities to ensure the success of the demonstration program; and

(I) to evaluate the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide.

(c) Evaluations.—Using such amounts made available pursuant to subsection (e) as the Secretary determines to be appropriate, the Secretary shall conduct, directly or through a grant, contract, cooperative agreement, or any other entity that has experience regarding the development and operation of successful culturally compatible, school-based, life skills suicide prevention and intervention programs or evaluations, at the completion of the demonstration program under this section, including an evaluation of—

(I) the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

(2) areas for program improvement; and

(3) additional development of the goals and objectives of the demonstration program.

(d) Report to Congress.—

(1) In General.—Subject to paragraph (2), not later than 180 days after the date of termination of the demonstration program, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Natural Resources of the House of Representatives a final report that—

(A) describes the results of the program of each Indian tribe or eligible entity under this section;

(B) evaluates the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

(C) makes recommendations regarding—

(i) the expansion of the demonstration program under this section to additional eligible entities;

(ii) designating the demonstration program as a permanent program; and

(iii) identifying and distributing the curriculum through the Behavioral Health Resource Center of the Administration; and

(D) incorporates any public comments received under paragraph (2).

(2) Public Comment.—The Secretary shall provide a notice of the report under paragraph (1) and an opportunity for public comment on the report for a period of not less than 30 days before submitting the report to Congress.

(3) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2010 through 2014.

Subtitle H—Miscellaneous

SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED PRIMARY CARE IMPACTS.

Title VIII of the Indian Health Care Improvement Act (as amended by section
SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

(a) Definitions.—In this section:

(1) Health care provider.—The term ‘health care provider’ means any health care professional, company, consultant, or aide and practitioners certified under section 119, who is—

(A) granted clinical practice privileges or employed to provide health care services at—

(i) an Indian health program; or

(ii) a health program of an urban Indian organization;

(B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization; or

(2) Medical quality assurance program.—The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 by or for any Indian health program or urban Indian organization to assess the competence of medical care, including activities conducted by or on behalf of individuals, Indian health program or urban Indian organization medical staff, or health care providers or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review, and identification and prevention of medical or dental incidents or risks.

(3) Medical quality assurance record.—The term ‘medical quality assurance record’ means the proceedings, records, minutes, and reports that—

(A) emanate from quality assurance program activities described in paragraph (2); and

(B) are produced or compiled by or for an Indian health program or urban Indian organization as part of a medical quality assurance program.

(b) Confidentiality of records.—Medical quality assurance records created by or for any Indian health program or a health program of an urban Indian organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (d).

(c) Prohibition on Disclosure and Testimony.—

(1) In General.—No part of any medical quality assurance record described in subsection (b) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (d).

(2) Prohibition.—An individual who reviews or creates medical quality assurance records for any Indian health program or urban Indian organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

(d) Authorized Disclosure and Testimony.—

(1) In General.—Subject to paragraph (2), a medical quality assurance record described in subsection (b) may be disclosed, and an individual referred to in subsection (c) may give testimony in connection with such a record, only as follows:

(A) To a Federal agency or private organization, if such medical quality assurance record pertains to a record of such agency or organization to perform licensing or accreditation functions related to any Indian health program or to a health program of an urban Indian organization; or

(B) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

(2) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of an individual who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

(E) To an officer, employee, or contractor of the Indian health program or urban Indian organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

(F) To a criminal or civil law enforcement agency or instrumentality charged with the enforcement of any Federal law relating to the health or safety of any person, or a criminal or civil law enforcement agency or instrumentality charged with the enforcement of any law or executive order or with the performance of any function relating to the enforcement of such laws or orders, if that officer, employee, or contractor has a need for such record or testimony to perform official duties.

(G) To an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality charged with the enforcement of any Federal law, if that officer, employee, or contractor has a need for such record or testimony to perform official duties.

(2) Withholding from Congress.—Nothing in this section shall be construed as authorizing or requiring the testimonial or written disclosure of information otherwise protected from disclosure to members of Congress, the Senate, or any other congressional committee, unless such information is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

(3) To a professional health care society or organization, if such medical quality assurance record or testimony is needed by such society or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

(e) Disclosure for Certain Purposes.—

(1) In General.—Nothing in this section shall be construed as authorizing or requiring the testimonial disclosure of any information otherwise protected from disclosure to the extent that such information is needed by a Tribal or Indian health organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

(f) Prohibition on Disclosure of Records and Testimony Described by this Section.—The States of North Dakota and South Dakota as Contract Health Service Delivery Areas for Eligibility of California Indians. (a) In General.—The States of Arizona, North Dakota, and South Dakota shall be designated as contract health service delivery areas for the purposes of providing contract health services to members of Indian tribes in the State of Arizona.

(b) Maintenance of Services.—The Service shall not curtail any contract health services provided to Indians residing on reservations in the State of Arizona if the curtailment is due to the provision of contract services in the States of North Dakota and South Dakota as contract health service delivery area by subsection (a).
as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

"(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on any reservation, the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services pursuant to the determination of the State of North Dakota or South Dakota that there is an Indian health service delivery area by the Service under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such Indian.

"SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a federally recognized Indian tribe;

"(2) Any descendant of an Indian who was residing in California on June 1, 1862, if such descendant—

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotment.

"(4) Any Indian of California who is listed on the plans for distribution of the assets of ranchores and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) CLARIFICATION.—Nothing in this section shall be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that existed on August 18, 1958.

SEC. 193. METHODS TO INCREASE ACCESS TO PROFESSIONALS OF CERTAIN CORPS.

Section 812 of the Indian Health Care Improvement Act (25 U.S.C. 168b) is amended to read as follows:

"SEC. 812. NATIONAL HEALTH SERVICE CORPS.

"(a) INCLUSION OF IN SERVICES.—The Secretary shall not remove a member of the National Health Service Corps from an Indian health program or urban Indian organization or vice versa unless it is determined that the member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from the member will not be adversely affected.

"(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian health program, the services of a member of the National Health Service Corps assigned to the Indian health program may be limited to the individuals who are eligible for services from that Indian health program.

SEC. 194. HEALTH SERVICES FOR INELIGIBLE PERSONS.

Section 813 of the Indian Health Care Improvement Act (25 U.S.C. 168b) is amended to read as follows:

"SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.

"(a) Eligible.—Any individual who—

"(1) has not attained 19 years of age;

"(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian;

"(3) is not otherwise eligible for health services provided by the Service.

shall be eligible for all health services provided by the Service on the same basis and subject to the same conditions that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such individual is legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services for 1 year after the date of a determination of competency.

"(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but otherwise eligible for the health services provided by the Service, shall be eligible for such services if all such spouses or spouses who are married to or otherwise eligible for such services are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(c) HEALTH FACILITIES PROVIDING HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the State of California.

"(2) Any Indian tribe or tribal organization of the State of California shall provide health services under this subsection through health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing such services shall be deemed to be an Indian tribe or tribal organization under section 401(d) of title 20, United States Code.

"(3) PAYMENT FOR SERVICES.—(A) In general.—The Service shall be responsible for reimbursement in an amount not less than the actual cost of providing the health service, and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

"(4) RECOVERY OF CONSENT FOR SERVICES.—

"(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTITRIBAL SERVICE AREA.—In the case of a multitudinal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year in which at least 51 percent of the number of Indian tribes in the Service Area revoke their concurrence to the provisions of such health services.

"(C) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian’s child for the duration of the pregnancy through postpartum; or

"(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

"(c) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

"(1) IN GENERAL.—Hospital privileges in health care facilities operated by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of sections 1395s(b) and chapter 171 of title 26, United States Code (relating to payment of taxes on Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

"(2) DEFINITION.—For purposes of this subsection, the term ‘non-Service health care practitioner’ means a practitioner who is not—

"(A) an employee of the Service; or

"(B) an employee of an Indian tribe or tribal organization operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an individual who provides health services under a contract or a personal services contract with such Indian tribe or tribal organization.
SEC. 827. PRESCRIPTION DRUG MONITORING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding, at the end the following:

"(D) any statutory or administrative barriers to the provision of health care services to that abuse; and

(2) the size of the population served by the Service..."

SEC. 828. ANNUAL BUDGET SUBMISSION.

Effective beginning with the submission of the annual budget request to Congress for fiscal year 2011, the President shall include, in the amount requested and the budget justification, amounts that reflect any changes in—

(1) the cost of health care services, as indexed for United States dollar inflation (as measured by the Consumer Price Index); and

(2) the size of the population served by the Service..."

SEC. 829. PRESCRIPTION DRUG MONITORING.

"(a) MONITORING.—

(1) ESTABLISHMENT.—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program to be carried out at health care facilities of the Service, tribal health care facilities, and urban Indian health care facilities...

(2) Within 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

(A) the needs of the Service, tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program described in paragraph (1);

(B) the planned development of that program, including any relevant statutory or administrative limitations; and

(C) the means by which the program could be carried out in coordination with any State prescription drug monitoring program.

(b) ABUSE.—

(1) IN GENERAL.—The Attorney General, in consultation with the Secretary of the Interior and the Secretary of Health and Human Services, shall conduct a study, and evaluate the effectiveness of those activities, including the reductions of injury or disease conditions achieved by the activities..."

SEC. 830. OTHER GAO REPORTS.

"(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall conduct a study and evaluate the effectiveness of coordination of health care services provided to Indians—

(A) through Medicare, Medicaid, or SCHIP;

(B) by the Service; or

(C) using funds provided by—

(i) State or local governments;

(ii) Indian tribes...

(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report—

(A) describing the results of the evaluation under paragraph (1); and

(B) containing recommendations of the Comptroller General regarding measures to support and increase coordination of the provision of health care services to Indians as described in paragraph (1)."

"(c) BARER.—Nothing in this Act shall be construed to alter any liability or other obligation that the United States may otherwise have to provide health care services to an Indian patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have to provide health care services to an Indian patient. Nothing in this subsection shall be..."
HIV/AIDS Prevention and Treatment (referred to in this section as the ‘Director’).

(b) DUTIES.—The Director shall—

(1) coordinate and promote HIV/AIDS prevention and treatment activities specific to Indians;

(2) provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations regarding existing HIV/AIDS prevention and treatment programs; and

(3) ensure interagency coordination to facilitate the inclusion of Indians in Federal HIV/AIDS research and grant opportunities, with emphasis on the programs operated under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101–508) and the amendments made by that Act.

(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, and not less frequently than once every 2 years thereafter, the Director shall submit to Congress a report describing, with respect to the preceding 2-year period—

(1) each activity carried out under this section; and

(2) any findings of the Director with respect to HIV/AIDS prevention and treatment activities specific to Indians.

TITIE II—AMENDMENTS TO OTHER ACTS

SEC. 201. MEDICARE AMENDMENTS.

(a) LONG-TERM CARE.—Section 1880 of the Social Security Act (42 U.S.C. 1395(g)) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following:

“(f) PROHIBITION.—Payments made pursuant to this section shall not be reduced as a result of any beneficiary deductible, coinsurance, or other charge under section 1813.”.

(b) PAYMENT OF BENEFITS.—Section 1893(a)(3) of the Social Security Act (42 U.S.C. 1395(a)(3)) is amended by inserting “or 1880(c)” after “section 1861(a)(10)(A)”.

SEC. 202. REAUTHORIZATION OF NATIVE HAWAIIAN HEALTH CARE PROGRAMS.

(a) REAUTHORIZATION.—The Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is amended by striking “2001” each place where it appears in sections 6(b)(1), 7(b), and 16(c) (42 U.S.C. 11706(b)(1), 11706(b), 11706(c)) and inserting “2019”.

(b) HEALTH AND EDUCATION.

(1) In subsection (b)(6) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11705) is amended by adding at the end the following:

“(4) HEALTH AND EDUCATION.—In order to enable privately funded organizations to continue to supplement public efforts to provide educational programs designed to improve the health, capacity, and well-being of Native Hawaiians and to continue to provide health services to Native Hawaiians, notwithstanding any other provision of Federal law, it shall be lawful for the private educational organization identified in section 7202(16) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7252(16)) to continue to offer its educational programs and services to Native Hawaiians (as defined in section 7207 of that Act (20 U.S.C. 7517)) first and to others only after the need for such programs and services by Native Hawaiians has been met.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on December 5, 2009.

(c) DEFINITION OF HEALTH PROMOTION.—Section 12(2) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11711(2)) is amended—

(1) in subparagraph (F), by striking “and” at the end;

(2) in subparagraph (G), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following:

“(H) educational programs with the mission of improving the health capability, and well-being of Native Hawaiians.”.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sarah Allen, Ryan Nalty, and Grant Jamieson, staff of the Finance Committee, be granted the privilege of the floor for the duration of debate on the health care bill.

The PRESIDENT pro tempore.

Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sara Velde of Senator HARKIN’s staff be granted the privilege of the floor during the duration of today’s session.

The ACTING PRESIDENT pro tempore.

Without objection, it is so ordered.

DISCHARGE AND REFERRAL—S. 2129

Mr. BAUCUS. I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be discharged from further consideration of S. 2129 and the bill be referred to the Committee on Environment and Public Works.

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

SUPPORTING PEACE, SECURITY, AND INNOCENT CIVILIANS AFFECTED BY CONFLICT IN YEMEN

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 212, S. Res. 341.

The PRESIDENT OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 341) supporting peace, security, and innocent civilians affected by conflict in Yemen.

There being no objection, the Senate proceeded to consider the resolution.

Mr. BAUCUS. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 341) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

Resolved. That the Senate—

(1) supports the innocent civilians in Yemen, especially displaced persons, who have suffered from instability, terrorist operations, and chronic underdevelopment in Yemen;

(2) recognizes the serious threat instability and terrorism in Yemen pose to the security of the United States, the region, and the population in Yemen;

(3) calls on the President to give sufficient weight to the situation in Yemen in efforts to prevent terrorist attacks on the United States, United States allies, and Yemeni civilians;

(4) calls on the President to promote economic and political reforms necessary to advance economic development and good governance in Yemen;

Whereas this security challenges are compounded by a lack of governance throughout portions of the country;

Whereas this lack of governance creates a de facto safe haven for Qaeda and militant forces in regions of Yemen;

Whereas Yemen also faces significant development challenges, reflected in its rank of 140 out of 182 countries in the United Nations Development Program’s 2009 Human Development Index;

Whereas Yemen is also confronted with large numbers of displaced persons who have fled their homes in northern Yemen since 2004 in response to conflict between Government of Yemen forces and al-Houthi rebel forces; and

Whereas the people and Government of Yemen currently face tremendous security challenges, including the presence of a substantial number of al Qaeda militants, a rebellion in the northern part of the country, unrest in southern regions, and piracy in the Gulf of Aden;

Whereas government subsidies are contributing to the depletion of Yemen’s scarce resources;

Whereas the people of Yemen suffer from a lack of certain government services, including a robust education and skills training system;

Whereas the Department of State’s 2009 International Religious Freedom Report notes that nearly all of the once-sizeable Jewish population in Yemen has emigrated, and, based on fears for the Jewish community’s safety in the country, the United States Government has initiated a special program to refer Yemeni Jews for refuge resettlement in the United States;

Whereas Yemen currently face tremendous security challenges, including the presence of a substantial number of al Qaeda militants, a rebellion in the northern part of the country, unrest in southern regions, and piracy in the Gulf of Aden;

Whereas these security challenges are compounded by a lack of governance throughout portions of the country;

Whereas this lack of governance creates a de facto safe haven for Qaeda and militant forces in regions of Yemen;
(5) applauds steps that have been taken by the President and the United Nations High Commissioner for Refugees to assist displaced persons in Yemen;
(6) urges the Government of Yemen and rebel forces to immediately halt hostilities, allow medical and humanitarian aid to reach civilians displaced by conflict, and create an environment that will enable a return to normal life for those displaced by the conflict; and
(7) calls on the President and international community to use all appropriate measures to assist the people of Yemen to prevent Yemen from becoming a failed state.

RELATIVE TO THE DEATH OF FORMER SENATOR PAULA F. HAWKINS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 370, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 370) relative to the death of Paula F. Hawkins, former United States Senator for the State of Florida.

There being no objection, the Senate proceeded to consider the resolution.

Mr. LeMIEUX. Mr. President, I rise to express my sorrow at the passing of former U.S. Senator Paula Hawkins and to pay tribute to her long life and groundbreaking career of public service.

A resident of central Florida, Paula Hawkins began her political career in 1972 when she was elected to Florida’s Public Services Commission where she served for two consecutive terms and worked to become a vibrant voice for consumers.

Paula Hawkins aspired to continue her public service by running for higher office, first for the U.S. Senate in 1974, and then for Lieutenant Governor in 1978. Though both times she lost the race, she never gave up and never lost the desire to continue working for Floridians.

Paula made history in 1980 when she became the first woman from Florida to be elected to the U.S. Senate and the first woman from Florida to be elected to Federal office.

During her tenure in the Senate, Senator Hawkins became an outspoken champion for America’s victimized children and brought a special focus to the problem of child abduction. Driven by the disappearance of 6-year-old Florida resident Adam Walsh, Senator Hawkins ushered passage of landmark legislation focusing on the issue of missing children. Her work would ultimately help to establish the National Center for Missing & Exploited Children. She also supported a special unit at the Federal Bureau of Investigation that would focus solely on profiling serial killers.

Though I am saddened by her passing, I am honored today to serve in the same class as Senator Hawkins—a seat she held before being succeeded by former Senator Bob Graham, and my predecessor, Senator Mel Martinez.

The United States Senate owe a debt of gratitude to this great Floridian and we shall not soon forget the work of Senator Hawkins.

Mr. BAUCUS. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table.

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

The resolution (S. Res. 370) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable Paula F. Hawkins, former member of the United States Senate.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable Paula F. Hawkins.

ORDERS FOR SATURDAY, DECEMBER 5, 2009

Mr. BAUCUS. I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. on Saturday, December 5, that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, with the first 3 hours following any leader remarks equally divided between the two leaders or their designees and controlled in 45-minute alternating blocks of time, with the majority controlling the first block, and with no other motions or amendments in order during the controlled time.

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

PROGRAM

Mr. BAUCUS. Mr. President, Senators should expect rollcall votes tomorrow afternoon. There will be no rollcall votes prior to 1 p.m.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BAUCUS. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the provisions of S. Res. 370, as a further mark of respect to the memory of the late Paula Hawkins, a former Senator from the State of Florida.

Thereupon, the Senate, at 6:50 p.m., adjourned until Saturday, December 5, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF TRANSPORTATION

DAVID L. STRECKLAND, OF GEORGIA, TO BE ADMINISTRATOR OF THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION. VICE NICOLE B. NASON, RESIGNED.

TENNESSEE VALLEY AUTHORITY

WILLIAM R. SANSOM, OF TENNESSEE, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY FOR A TERM EXPIRING MAY 18, 2014. (RE-APPOINTMENT)

DEPARTMENT OF STATE

JUDITH ANN STUART STOCK, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF STATE (EDUCATIONAL AND CULTURAL AFFAIRS), VICE GILLI AMERI, RESIGNED.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 601:

BRIG. GEN. MARY A. LIGGIER

TO BE MAJOR GENERAL

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

MAJ. GEN. THOMAS F. BOSTICK

TO BE LIEUTENANT GENERAL

MAJ. GEN. ROBERT L. CASCHEL, JR.
Daily Digest

Senate

Chamber Action

Routine Proceedings, pages S12355–S12460

Measures Introduced: Five bills and one resolution were introduced, as follows: S. 2836–2840, and S. Res. 370.

Measures Passed:

Supporting Civilians Affected by Conflict in Yemen: Senate agreed to S. Res. 341, supporting peace, security, and innocent civilians affected by conflict in Yemen.


Measures Considered:

Service Members Home Ownership Tax Act—Agreement: Senate continued consideration of H.R. 3590, to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, taking action on the following amendments proposed thereto:

Adopted:

By a unanimous vote of 98 yeas (Vote No. 359), Whitehouse Amendment No. 2870 (to Amendment No. 2786), to promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this Act. (A unanimous-consent agreement was reached providing that the amendment, having achieved 60 affirmative votes, be agreed to).

By 97 yeas to 1 nay (Vote No. 361), Stabenow Amendment No. 2899 (to Amendment No. 2786), to ensure that there is no reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans. (A unanimous-consent agreement was reached providing that the amendment, having achieved 60 affirmative votes, be agreed to).

Withdrawn:

By 51 yeas to 47 nays (Vote No. 360), Thune Amendment No. 2901 (to Amendment No. 2786), to eliminate new entitlement programs and limit the government control over the health care of American families. (A unanimous-consent agreement was reached providing that the amendment, having failed to achieve 60 affirmative votes, the amendment be withdrawn).

By 41 yeas to 57 nays (Vote No. 362), Hatch motion to commit the bill to the Committee on Finance, with instructions. (A unanimous-consent agreement was reached providing that the amendment, having failed to achieve 60 affirmative votes, the motion be withdrawn).

Pending:

Reid Amendment No. 2786, in the nature of a substitute.

Lincoln Amendment No. 2905 (to Amendment No. 2786), to modify the limit on excessive remuneration paid by certain health insurance providers to set the limit at the same level as the salary of the President of the United States.

Johanns motion to commit the bill to the Committee on Finance, with instructions.

A unanimous-consent-time agreement was reached providing for further consideration of the bill at approximately 10 a.m., on Saturday, December 5, 2009, with the first three hours following any Leader remarks equally divided between the two Leaders, or their designees, and controlled in 45 minute alternating blocks of time, with the Majority controlling the first block, and with no other motions or amendments in order during the controlled time.

National Women’s History Museum Act—Referral Agreement: A unanimous-consent agreement was reached providing that the Committee on Homeland Security and Governmental Affairs be discharged from further consideration of S. 2129, to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia to provide for the establishment of a National Women’s History Museum, and the bill then be referred to the Committee on Environment and Public Works.
Nominations Received: Senate received the following nominations:

- David L. Strickland, of Georgia, to be Administrator of the National Highway Traffic Safety Administration.
- William B. Sansom, of Tennessee, to be a Member of the Board of Directors of the Tennessee Valley Authority for a term expiring May 18, 2014.
- Judith Ann Stewart Stock, of Virginia, to be an Assistant Secretary of State (Educational and Cultural Affairs).
- 3 Army nominations in the rank of general.

Executive Communications: Pages S12412–13

Additional Cosponsors: Pages S12413–14

Statements on Introduced Bills/Resolutions: Pages S12414–15

Amendments Submitted Pages S12415–59

Privileges of the Floor: Page S12459

Record Votes: Four record votes were taken today. (Total—362) Pages S12395, S12396, S12396–97

Adjournment: Senate convened at 9:31 a.m. and adjourned, in accordance with S. Res. 370, at 6:50 p.m., until 10 a.m. on Saturday, December 5, 2009. (For Senate’s program, see the remarks of the Acting Majority Leader in today’s Record on page S12460.)

Committee Meetings

(Committees not listed did not meet)

No committee meetings were held.

House of Representatives

Chamber Action

The House was not in session today. The House is scheduled to meet at 10:30 a.m. on Monday, December 7, 2009.

Committee Meetings

No committee meetings were held.

Joint Meetings

EMPLOYMENT

Joint Economic Committee: Committee concluded hearings to examine the employment-unemployment situation for November 2009, after receiving testimony from Keith Hall, Commissioner, Bureau of Labor Statistics.

COMMITTEE MEETINGS FOR SATURDAY, DECEMBER 5, 2009

(Committee meetings are open unless otherwise indicated)

Senate
No meetings/hearings scheduled.

House
No committee meetings are scheduled.

CONGRESSIONAL PROGRAM AHEAD

Week of December 7 through December 12, 2009

Senate Chamber

Senate will continue consideration of H.R. 3590, Service Members Home Ownership Tax Act.

During the balance of the week, Senate may consider any cleared legislative and executive business.

Senate Committees

(Committee meetings are open unless otherwise indicated)

Committee on Armed Services: December 8, to hold hearings to examine Afghanistan, 1:30 p.m., SH–216.

Committee on Banking, Housing, and Urban Affairs: December 9, Subcommittee on Economic Policy, to hold hearings to examine creating jobs in the recession, 2 p.m., SD–538.

December 10, Subcommittee on Housing, Transportation and Community Development, to hold hearings to examine the Federal role in overseeing the safety of public transportation systems, 9:30 a.m., SD–538.

Committee on the Budget: December 10, to hold hearings to examine data-driven performance, focusing on using technology to deliver results, 10 a.m., SD–608.

Committee on Commerce, Science, and Transportation: December 9, to hold hearings to examine research parks and job creation, focusing on innovation through cooperation, 2:30 p.m., SR–253.

December 10, Subcommittee on Aviation Operations, Safety, and Security, to hold an oversight hearing to examine aviation safety, focusing on Federal Aviation Administration (FAA) safety initiatives, 10 a.m., SR–253.
Committee on Energy and Natural Resources: December 8, Subcommittee on Energy, to hold hearings to examine H.R. 957, to authorize higher education curriculum development and graduate training in advanced energy and green building technologies, H.R. 2729, to authorize the designation of National Environmental Research Parks by the Secretary of Energy, H.R. 3165, to provide for a program of wind energy research, development, and demonstration, H.R. 3246, to provide for a program of research, development, demonstration and commercial application in vehicle technologies at the Department of Energy, H.R. 3585, to guide and provide for United States research, development, and demonstration of solar energy technologies, S. 737, to amend the Energy Independence and Security Act of 2007 to authorize the Secretary of Energy to conduct research, development, and demonstration to make biofuels more compatible with small nonroad engines, S. 1617, to require the Secretary of Commerce to establish a program for the award of grants to States to establish revolving loan funds for small and medium-sized manufacturers to improve energy efficiency and produce clean energy technology, S. 2744, to amend the Energy Policy Act of 2005 to expand the authority for awarding technology prizes by the Secretary of Energy to include a financial award for separation of carbon dioxide from dilute sources, and S. 2773, to require the Secretary of Energy to carry out a program to support the research, demonstration, and development of commercial applications for offshore wind energy, 2:30 p.m., SD–366.

December 10, Full Committee, to hold hearings to examine the role of grid-scale energy storage in meeting our energy and climate goals, 10 a.m., SD–366.

Committee on Environment and Public Works: December 8, to hold an oversight hearing to examine Federal drinking water programs, 10 a.m., SD–406.

Committee on Finance: December 9, Subcommittee on International Trade, Customs, and Global Competitiveness, to hold hearings to examine exports’ place on the path of economic recovery, 2:30 p.m., SD–215.

Committee on Foreign Relations: December 8, business meeting to consider S. 1559, to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and the nominations of Rajiv J. Shah, of Washington, to be Administrator of the United States Agency for International Development, and Mary Burce Warlick, of Virginia, to be Ambassador to the Republic of Serbia, James B. Warlick, Jr., of Virginia, to be Ambassador to the Republic of Bulgaria, Eleni Tsakopoulos Kounalakis, of California, to be Ambassador to the Republic of Hungary, Leslie V. Rowe, of Washington, to be Ambassador to the Republic of Mozambique, Alberto M. Fernandez, of Virginia, to be Ambassador to the Republic of Equatorial Guinea, Mary Jo Wills, of the District of Columbia, to be Ambassador to the Republic of Mauritius, and to serve concurrently and without additional compensation as Ambassador to the Republic of Seychelles, Jide J. Zeitlin, of New York, to be Alternate Representative of the United States of America to the Sessions of the General Assembly of the United Nations during his tenure of service as Representative of the United States of America to the United Nations for U.N. Management and Reform, and to be Representative of the United States of America to the United Nations for U.N. Management and Reform, with the rank of Ambassador, Anne Slaughter Andrew, of Indiana, to be Ambassador to the Republic of Costa Rica, David Daniel Nelson, of Minnesota, to be Ambassador to the Oriental Republic of Uruguay, Betty E. King, of New York, to be Representative of the United States of America to the Office of the United Nations and Other International Organizations in Geneva, with the rank of Ambassador, Laura E. Kennedy, of New York, for the rank of Ambassador during her tenure of service as U.S. Representative to the Conference on Disarmament, and Bill Delahunt, of Massachusetts, Elaine Schuster, of Florida, and Christopher H. Smith, of New Jersey, all to be a Representative, and Laura Gore Ross, of New York, and Wellington E. Webb, of Colorado, both to be an Alternate Representative, all of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations, all of the Department of State, and any pending calendar business, 2:15 p.m., S–116, Capitol.

December 9, Full Committee, to hold hearings to examine the new Afghanistan strategy, focusing on the view from the ground, 10 a.m., SD–419.

December 9, Subcommittee on European Affairs, to hold hearings to examine strengthening the transatlantic economy, 2:30 p.m., SD–419.


December 10, Subcommittee on East Asian and Pacific Affairs, to hold hearings to examine principles for United States engagement in Asia, 2:30 p.m., SD–419.

Committee on Health, Education, Labor, and Pensions: December 9, business meeting to consider the nominations of Jacqueline A. Berrien, of New York, Victoria A. Liptic, of Virginia, Chai Rachel Feldblum, of Maryland, all to be a Member of the Equal Employment Opportunity Commission, P. David Lopez, of Arizona, to be General Counsel of the Equal Employment Opportunity Commission, Patrick Alfred Corvington, of Maryland, to be Chief Executive Officer of the Corporation for National and Community Service, Adele Logan Alexander, of the District of Columbia, to be a Member of the National Council on the Humanities, and Lynnae M. Rutledge, of Washington, to be Commissioner of the Rehabilitation Services Administration, Department of Education, 10 a.m., SD–430.
Committee on Homeland Security and Governmental Affairs: December 9, to hold hearings to examine five years after the Intelligence Reform and Terrorism Prevention Act, focusing on stopping terrorist travel, 10 a.m., SD–342.

December 9, Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, to hold hearings to examine the diplomat’s shield, focusing on diplomatic security today, 2:30 p.m., SD–342.

December 10, Full Committee, to hold hearings to examine the nominations of Grayling Grant Williams, of Maryland, to be Director of the Office of Counternarcotics Enforcement, and Elizabeth M. Harman, of Maryland, to be an Assistant Administrator of the Federal Emergency Management Agency, both of the Department of Homeland Security, 10 a.m., SD–342.

December 10, Ad Hoc Subcommittee on Disaster Recovery, to hold hearings to examine children and disaster victims, focusing on a progress report on addressing needs, 2:30 p.m., SD–342.

Committee on Indian Affairs: December 9, business meeting to consider pending calendar business; to be immediately followed by a hearing to examine S. 1690, to amend the Act of March 1, 1933, to transfer certain authority and resources to the Utah Dineh Corporation; to be immediately followed by an oversight hearing to examine Department of the Interior backlogs, 9:30 a.m., SD–628.

Committee on the Judiciary: December 9, to hold an oversight hearing to examine the Department of Homeland Security, 10 a.m., SH–216.

December 9, Full Committee, to hold hearings to examine mortgage fraud, securities fraud, and the financial meltdown, focusing on prosecuting those responsible, 2 p.m., SD–226.

December 10, Full Committee, business meeting to consider S. 448, to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media, S. 714, to establish the National Criminal Justice Commission, S. 1624, to amend title 11 of the United States Code, to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill, injured, or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems, S. 1765, to amend the Hate Crime Statistics Act to include crimes against the homeless, S. 678, to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, S. 1554, to amend the Juvenile Justice and Delinquency Prevention Act of 1974 to prevent later delinquency and improve the health and well-being of maltreated infants and toddlers through the development of local Court Teams for Maltreated Infants and Toddlers and the creation of a National Court Teams Resource Center to assist such Court Teams, S. 1789, to restore fairness to Federal cocaine sentencing, and the nominations of Rosanna Malouf Peterson, to be United States District Judge for the Eastern District of Washington, William M. Conley, to be United States District Judge for the Western District of Wisconsin, and Denny Chin, of New York, to be United States Circuit Judge for the Second Circuit, 10 a.m., SD–226.

Committee on Veterans’ Affairs: December 9, to hold hearings to examine the nominations of Robert A. Petzel, of Minnesota, to be Under Secretary for Health, and Raul Perea-Henze, of New York, to be Assistant Secretary for Policy and Planning, both of the Department of Veterans Affairs, 9:30 a.m., SR–418.

Select Committee on Intelligence: December 8, to hold closed hearings to consider certain intelligence matters, 2:30 p.m., S–407, Capitol.

December 10, Full Committee, to hold closed hearings to consider certain intelligence matters, 2:30 p.m., S–407, Capitol.

House Committees

Committee on Agriculture, December 9, Subcommittee on Conservation, Credit, Energy, and Research, hearing to review the regulatory and legislative strategies in the Chesapeake Bay watershed, 10 a.m., 1300 Longworth.

Committee on Appropriations, December 10, Subcommittee on Interior, Environment, and Related Agencies, oversight hearing on the Smithsonian Institution, 10 a.m., B–308 Rayburn.

Committee on Armed Services, December 8, to continue hearings on Afghanistan: The Results of the Strategic Review, Part II, 9:30 a.m., 210 HVC.

December 10, Subcommittee on Readiness, Air and Land Forces, and the Subcommittee on Seapower and Expeditionary Forces, joint hearing on Status of Army and Marine Corps Reset Requirements, Part II, 10 a.m., 210 HVC.

Committee on the Budget, December 9, hearing on The Social Safety Net: Impact of the Recession and of the Recovery Act, 10 a.m., 210 Cannon.

Committee on Education and Labor, December 8, hearing on Improving Our Competitiveness: Common Core Education Standards, 10 a.m., 2175 Rayburn.


Committee on Financial Services, December 8, hearing entitled “The Private Sector and Government Response to the Mortgage Foreclosure Crisis,” 10 a.m., 2128 Rayburn.


Committee on Foreign Affairs, December 9, Subcommittee on Terrorism, Nonproliferation, and Trade, hearing on A Strategic and Economic Review of Aerospace Exports, 2 p.m., 2200 Rayburn.
December 9, Subcommittee on the Western Hemisphere, hearing on New Direction or Old Path? Caribbean Basin Security Initiative (CBSI), 2 p.m., 2172 Rayburn.

December 10, full Committee, to continue hearings on U.S. Strategy in Afghanistan, Part II, 9:30 a.m., 2172 Rayburn.


Committee on the Judiciary, December 8 and 10, Task Force on Judicial Impeachment, to consider possible Impeachment of United States District Judge G. Thomas Porteous, Jr., Part II, 10 a.m., on December 8, and Part III, 10:30 a.m., on December 10, 2141 Rayburn.

December 8, Subcommittee on the Constitution, Civil Rights and Civil Liberties, hearing on the Impact of Federal Habeas Corpus Limitations on Death Penalty Appeals, 1 p.m., 2237 Rayburn.

December 10, Subcommittee on Courts and Competition Policy, hearing on Examining the State of Judicial Recusals after Caperton v. A.T. Massey, 1 p.m., 2237 Rayburn.


December 9, Subcommittee on National Security and Foreign Affairs, hearing entitled “U.S. aid to Pakistan: Planning and Accountability,” 10 a.m., 2154 Rayburn.

December 10, full Committee, to consider pending business, 10 a.m., 2154 Rayburn.


Committee on Rules, December 8, to consider the following: H.R. 4173, Wall Street Reform and Consumer Protection Act of 2009; and the Tax Extenders Act of 2009, 3 p.m., H–313 Capitol.

Committee on Science and Technology, December 10, hearing on Decisions on the Future Direction and Funding for NASA: What Will They Mean for the U.S. Aerospace Workforce and Industrial Base? 10 a.m., 2318 Rayburn.

Committee on Transportation and Infrastructure, December 8, Subcommittee on Highways and Transit, hearing on Public Transit Safety: Examining the Federal Role, 10 a.m., 2167 Rayburn.

December 9, Subcommittee on Coast Guard and Maritime Transportation, hearing on Maritime Domain Awareness, 2 p.m., 2167 Rayburn.

December 9, Subcommittee on Water Resources and Environment, hearing on the One-Year Anniversary of the Tennessee Valley Authority’s Kingston Ash Slide: Evaluating Current Cleanup Progress and Assessing Future Environmental Goals, 10 a.m., 2167 Rayburn.

December 10, full Committee, hearing on Recovery Act: Progress Report for Transportation Infrastructure Investment, 10 a.m., 2167 Rayburn.

Committee on Veterans’ Affairs, December 9, Subcommittee on Oversight and Investigations, hearing on Acquisition Deficiencies at the U.S. Department of Veterans Affairs, 10 a.m., 334 Cannon.

Permanent Select Committee on Intelligence, December 8, executive, briefing on NSA Update, 4:30 p.m., 304 HVC.

December 9, executive, briefing on Afghanistan/Pakistan Update, 11 a.m., 304–HVC.

Joint Meetings

Joint Economic Committee: December 10, to hold hearings to examine the challenge of creating jobs in the aftermath of the recession, 10 a.m., 210 Cannon Building.
Next Meeting of the SENATE
10 a.m., Saturday, December 5

Senate Chamber
Program for Saturday: Senate will continue consideration of H.R. 3590, Service Members Home Ownership Tax Act, with a series of rollcall votes expected after 1 p.m.

Next Meeting of the HOUSE OF REPRESENTATIVES
10:30 a.m., Monday, December 7

House Chamber
Program for Monday: To be announced.