S. CON. RES. 39

At the request of Mrs. CLINTON, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution to express the sense of Congress on the Purple Heart.

S. RES. 39

At the request of Mr. MCCONNELL, his name was added as a cosponsor of S. Res. 39, a resolution apologizing to the victims of lynching and the descendants of those victims for the failure of the Senate to enact anti-lynching legislation.

At the request of Mr. BUNNING, his name was added as a cosponsor of S. Res. 39, supra.

At the request of Mr. MARTINEZ, his name was added as a cosponsor of S. Res. 39, supra.

At the request of Mr. BURNS, his name was added as a cosponsor of S. Res. 39, supra.

At the request of Ms. LANDRIEU, the names of the Senator from Ohio (Mr. DEWINE), the Senator from North Carolina (Mrs. DOLE), the Senator from West Virginia (Mr. ROCKEFELLER), the Senator from South Dakota (Mr. THUNE), the Senator from Oregon (Mr. WYDEN), the Senator from Virginia (Mr. WARNER), the Senator from Montana (Mr. BAUCUS), the Senator from Kansas (Mr. ROBERTS), the Senator from Rhode Island (Mr. CHAFEE) and the Senator from Alabama (Mr. SESSIONS) were added as cosponsors of S. Res. 39, supra.

At the request of Mr. ALLEN, the names of the Senator from Missouri (Mr. BOND), the Senator from Georgia (Mr. CHAMBLISS), the Senator from Georgia (Mr. ISAKSON) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. Res. 39, supra.

S. RES. 86

At the request of Mr. HAGEL, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. Res. 86, a resolution designating August 16, 2005, as ''National Airborne Day''.

S. RES. 154

At the request of Mr. BIDEN, the names of the Senator from Colorado (Mr. SALAZAR), the Senator from Ohio (Mr. VOINOVICH) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. Res. 154, a resolution designating October 21, 2005 as ''National Mammography Day''.

S. RES. 155

At the request of Mr. BIDEN, the names of the Senator from South Dakota (Mr. JOHNSON) and the Senator from North Dakota (Mr. CONRAD) were added as cosponsors of S. Res. 155, a resolution designating the week of November 6 through November 12, 2005, as ''National Veterans Awareness Week'' to emphasize the need to develop educational programs regarding the contributions of veterans to the country.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself and Ms. LANDRIEU):

S. 1225. A bill to expand access to affordable health care and to strengthen the health care safety net and make health care services more available in rural and underserved areas; to the Committee on Finance.

Ms. COLLINS. Mr. President, I am pleased to join with my colleague from Louisiana, Senator LANDRIEU, in introducing the Access to Affordable Health Care Act, a comprehensive, seven-point plan that builds on the strengths of our current public programs and private health care system to make quality, affordable health care available to millions more Americans.

One of my top priorities in the Senate has been to expand access to affordable health care for all Americans. There are still far too many Americans without health insurance or with woefully inadequate coverage. As many as 45 million Americans—almost 16 percent of our population—are uninsured, and millions more are underinsured.

Health care coverage matters. The simple fact is that people with health insurance are healthier than those who are uninsured. People without health insurance are less likely to seek care when they need it, and to forgo services such as periodic check ups and preventive services. As a consequence, they are more likely to be hospitalized or require costly medical attention for conditions that could have been prevented or treated at a curable stage. Not only does this put the health of these individuals at greater risk, but it also puts additional pressure on our hospitals and emergency rooms, many of them already financially challenged.

Compared with people who have health coverage, uninsured adults are four times, and uninsured children five times, more likely to use the emergency rooms. The costs of care for these individuals are often absorbed by providers and passed on to the covered population through increased fees and insurance premiums.

Maine is in the midst of a growing health insurance crisis, with insurance premiums rising at alarming rates. Whether I am talking to a self-employed fisherman, a displaced worker, the owner of a struggling small business, or the human resource manager of a large company, the soaring costs of health insurance is a common concern.

Maine's employers are currently facing premium increases of as much as 20 percent a year. These premiums have been particularly burdensome for small businesses, the backbone of the Maine economy. Many small business owners are caught in a cost-squeeze: they know that if they pass on the premium increases to their employees, more of them will decline coverage. Yet these small businesses simply cannot afford to absorb double-digit increases in their health insurance premiums year after year.

The problem of rising costs is even more acute for individuals and families who must purchase health insurance on their own. Monthly health insurance premiums in Maine often exceed a family's mortgage payment. It is no wonder that as many as 150,000 Mainers are uninsured. Clearly, we must do more to make our health care system more efficient and health insurance more available and affordable.

The Access to Affordable Health Care Act, which we are introducing today, is a seven-point plan that combines a variety of public and private approaches to make quality health care coverage more affordable and available. The legislation's seven goals are:

No. 1. To expand access to affordable health care for small businesses;

No. 2. To make health insurance more affordable for individuals and families purchasing coverage on their own;

No. 3. To strengthen the health care safety net for those without coverage;

No. 4. To expand access to care in rural and under-served areas;

No. 5. To increase access to affordable long-term care;

No. 6. To promote healthier lifestyles;

And No. 7, to provide more equitable Medicare payments to Maine providers to reduce the Medicare shortfall, which has forced hospitals, physicians and other providers to shift costs onto other payers in the form of higher charges, which, in turn drives up health care premiums.

Let me discuss each of these seven points in more detail.

First, our legislation will help small employers cope with rising health care costs.

Since most Americans get their health insurance through the workplace, it is a common assumption that people without health insurance are unemployed. The fact is, however, that most uninsured Americans are members of families with at least one full-time worker. As many as 82 percent of Americans who do not have health insurance are in a family with a worker.

Uninsured working Americans are most often employees of small businesses. In fact, some 60 percent of uninsured workers are employed by small firms. Smaller firms generally face higher costs for health insurance than larger firms, which makes them less likely to offer coverage. Small businesses want to provide health insurance for their employees, but the cost of often just too high.

The legislation we are introducing today will help small employers cope with rising costs by providing new tax credits for small businesses to help make health insurance more affordable. It will encourage those small businesses that do not currently offer health insurance to do so and will help employers that do offer insurance to continue coverage for their employees even in the face of rising costs.

Our legislation will also help increase the clout of small businesses in

negotiating with insurers. Premiums are generally higher for small businesses because they do not have as much purchasing power as large companies, which limits their ability to bargain for lower rates. They also have higher administrative costs because they have fewer employees among whom to spread the fixed cost of a health benefits plan. Moreover, they are not as able to spread the risks of medical claims over as many employees as large firms.

Our legislation will help address these problems by authorizing Federal grants to provide start-up funding to States to assist them with the planning, development and operation of small employer purchasing cooperatives. These cooperatives will help to reduce health care costs for small employers by allowing them to band together to purchase health insurance jointly. Group purchasing cooperatives have a number of advantages for small employers. For example, the increased number of participants in the group help to lower the premium costs for all. Moreover, they decrease the risk of adverse selection and spread the cost of health care over a broader group.

The legislation would also authorize a Small Business Administration grant program for States, local governments and non-profit organizations to provide information about the benefits of health insurance to small employers, including tax benefits, increased productivity of employees, and decreased turnover. These grants would also be used to make employers aware of their current rights under State and Federal laws. While costs are clearly a problem, many small employers are not fully aware of laws that have already been enacted by both States and Federal Government to make health insurance more affordable. For example, in one survey, 57 percent of small employers did not know that they could deduct 100 percent of their health insurance premiums as a business expense.

The legislation would also create a new program to encourage innovation by awarding demonstration grants in up to 10 States conducting innovative coverage expansions, such as alternative group purchasing or pooling arrangements, individual or small group market reforms, or subsidies to employers or individuals purchasing coverage. The States have long been laboratories for reform, and they should be encouraged in the development of innovative programs that can serve as models for the Nation.

The Access to Affordable Health Care Act will also expand access to affordable health care for individuals and families.

One of the first bills I cosponsored as a Senator was legislation to establish the State Children's Health Insurance Program, S–CHIP, which provides insurance for the children of low-income parents who cannot afford health insurance, yet make too much money to qualify for Medicaid. This important program has provided affordable health insurance coverage to an estimated six million children nationwide, including almost 13,000 who are currently enrolled in the MaineCare program. Even so, nationwide, millions of qualified children have yet to be enrolled in this program, many because their parents simply don't know that they are eligible for the assistance.

Our legislation builds on the success of this program and gives States a number of new tools to increase participation. The bill authorizes new grants for States and non-profit organizations to conduct innovative outreach and enrollment efforts to ensure that all eligible children are covered. States would also have the option of covering the parents of the children who are enrolled in programs like MaineCare. States could also use funds provided through this program to help eligible working families pay their share of an employer-based health insurance plan. In short, the legislation will help ensure that the entire family receives the health care they need.

And finally, to help make health coverage more affordable for low- and middle-income individuals and families who do not have employer-provided coverage and who are not eligible for the expanded public programs, our legislation would provide an advanceable, refundable tax credit of up to $1,000 for individuals earning up to $30,000 and up to $3,000 for families earning up to $60,000. This could provide coverage for up to 6 million Americans who would otherwise be uninsured for one or more months, and will help many more working lower-income families who currently purchase private health insurance with little or no government help.

The Access to Affordable Health Insurance Act will also help to strengthen our Nation's health care safety net by doubling funding over 5 years for the Consolidated Health Centers program, which includes community, migrant, public housing and homeless health centers. These centers, which operate in underserved urban and rural communities, provide critical primary care services to millions of Americans, regardless of their ability to pay. About 20 percent of the patients treated at Maine's community health centers have no insurance coverage and many more have inadequate coverage, so these centers are a critical part of our Nation's health care safety net.

The problem of access to affordable health care services is not limited to the uninsured, but is also shared by many Americans living in rural and underserved areas where there is a serious shortage of health care providers. The Access to Affordable Health Care Act therefore calls for increased funding for the National Health Service Corps, which supports doctors, dentists, and other clinicians who serve in rural and inner city areas.

The legislation will also give the program greater flexibility by allowing National Health Service Corps participants to fulfill their commitment on a part-time basis. Current law requires all National Health Service Corps participants to serve full-time. Many rural communities, however, simply do not have enough volume to support a full-time health care practitioner. Moreover, some sites may not need a particular type of provider—for example, a dentist—on a full-time basis. Some practitioners may also find part-time service more attractive, which, in turn, could improve recruitment and retention. Our bill therefore gives the program additional flexibility to meet community needs.

Long-term care is the major catastrophic health care expense faced by older Americans today, and these costs will only increase with the aging of the baby boomers. Most Americans mistakenly believe that medicare or their private health insurance policies will cover the cost of long-term care should they develop a chronic illness or cognitive impairment like Alzheimer's Disease. Unfortunately, far too many do not discover that they do not have coverage until they are confronted with the difficult decision of placing a much-loved parent or spouse in long-term care and facing the shocking realization that they will have to cover the costs themselves.

The Access to Affordable Health Care Act will provide a tax credit for long-term care expenses of up to $3,000 to provide some help to those families struggling to provide long-term care to a loved one. It will also encourage more Americans to plan for their future long-term care needs by providing a tax deduction to help them purchase long-term care insurance.

Health insurance alone is not going to ensure good health. As noted author and physician Dr. Michael Crichton has observed, ''the future of medicine lies not in treating illness, but preventing it.'' Many of our most serious health problems are directly related to unhealthy behaviors—smoking, lack of regular exercise and poor diet. These three major risk factors alone have made Maine the state with the fourth highest death rate due to four largely preventable diseases: cardiovascular disease, cancer, chronic lung disease and diabetes. These four chronic diseases are responsible for 70 percent of the health care problems in Maine.

Our bill therefore contains a number of provisions designed to promote healthy lifestyles. An ever-expanding body of evidence shows that these kinds of investments in health promotion and prevention offer returns not only in reduced health care bills, but in longer life and increased productivity. The legislation will provide grants to States to assist small businesses wishing to establish ''worksite wellness'' programs for their employees. It would also authorize a grant program to support new and existing ''community partnerships,'' such as the Healthy Community Coalition in

Maine's Franklin County, to promote healthy lifestyles among hospitals, employers, schools and community organizations. And, it would provide funds for States to establish or expand comprehensive school health education, including, for example, physical education programs that promote lifelong physical activity, healthy food service selections, and programs that promote a healthy and safe school environment.

Finally, the Access to Affordable Health Care Act would promote greater equity in Medicare payments and help to ensure that the Medicare system rewards rather than punishes States like Maine that deliver high-quality, cost-effective Medicare services to our elderly and disabled citizens.

According to a study in the Journal of the American Medical Association, Maine ranks third in the Nation when it comes to the quality of care delivered to our Medicare beneficiaries. Yet we are 11th from the bottom when it comes to per-beneficiary Medicare spending.

The fact is that Maine's Medicare dollars are being used to subsidize higher reimbursements in other parts of the country. This simply is not fair. Medicare's reimbursement systems have historically tended to favor urban areas and failed to take the special needs of rural States into account. Ironically, Maine's low payment rates are also the result of its long history of providing high-quality, cost-effective care. In the early 1980s, Maine's lower than average costs were used to justify lower payment rates. Since then, Medicare's payment policies have only served to perpetuate the gap.

The Medicare Modernization Act of 2003 did take some significant steps toward promoting greater fairness by increasing Medicare payments to rural hospitals and by modifying geographic adjustment factors that discriminated against physicians and other providers in rural areas. The legislation we are introducing today will build on those improvements by establishing State pilot programs that reward providers of high-quality, cost efficient Medicare services. It will also establish a program to expand graduate medical education programs in rural and underserved areas of the nation.

Mr. President, the Access to Affordable Health Care Act outlines a blueprint for reform based on principles upon which I believe a bipartisan majority in Congress could agree. The plan takes significant strides toward the goal of universal health care coverage by bringing millions more Americans into the insurance system, by strengthening the health care safety net, and by addressing inequities in the Medicare system.

By Mr. AKAKA:

S. 1226. A bill to provide jurisdiction over Federal contractors who engage in human trafficking offenses; to the Committee on the Judiciary.

Mr. AKAKA. Mr. President, I rise today to introduce the Federal Contractor Extraterritorial Jurisdiction for Human Trafficking Offenses Act of 2005, which builds upon bipartisan efforts to combat the abhorrent practice of human trafficking.

Human trafficking is unfortunately among the fastest growing international criminal activities. According to the U.S. State Department's 2005 Trafficking in Persons Report, 600,000 to 800,000 victims are transported across international borders each year. These victims often come from the world's most vulnerable populations and regions affected by wars or humanitarian disasters.

With the promise of well-paying jobs, victims are often enticed to foreign countries, where upon arrival, their passports or travel papers are confiscated, and they are forced, many times beaten, until they agree to work without pay or serve as prostitutes. The perpetrators of human trafficking are typically motivated by profits derived from the use of forced labor or commercial sex exploitation. Because one of the common motivations of trafficking is forced prostitution: 80 percent of the victims are women and 50 percent of the victims are children.

In 2001, awareness of human trafficking grew in London during a murder investigation where the victim was a small African boy. While trying to determine the identity of the victim, investigators discovered that, in London alone, 300 African children between the ages of 4 and 7 could not be accounted for. That staggering statistic provides an insight into the pervasiveness of child trafficking and demonstrates that it can occur in all countries, including the most affluent.

This issue has long been a concern of mine. Nearly 6 years ago, I learned of a human trafficking ring that enslaved foreign workers and smuggled them to the U.S. Commonwealth of the Northern Mariana Islands, CNMI. The workers were forced to work in factories or serve as prostitutes. Senators Frank Murkowski, Jeff Bingaman, and I introduced S. 1052 to tighten immigration law in the CNMI to prevent future human trafficking rings. Although our bill passed the Senate, it was not taken up in the House.

Unfortunately, that was only one of numerous human trafficking conspiracies discovered within the United States. The State Department estimates that 14,500 to 17,500 human trafficking victims are brought into our country every year.

We cannot address this issue without recognizing the efforts of my friend and departed colleague, Senator Paul Wellstone, who through his leadership, the Victims of Trafficking and Violence Protection Act of 2000, P.L. 106–386, was enacted. This law first established our Nation's commitment to the prosecution of traffickers and the protection of victims of trafficking.

Since 2000, and the passage of this Act, there has been a surge in government activity relating to the prevention and prosecution of human trafficking offenses. In 2003 alone, there were approximately 3,000 convictions of human traffickers worldwide.

We have learned a great deal more about the conditions under which members of a population are likely to become victims of trafficking. Those who are displaced from their homes or suffering from poverty are much more likely to become victims of trafficking. Unfortunately, military forces and organizations charged with protecting and providing for vulnerable populations have, at times, actually encouraged the trafficking of humans.

There have been instances in the Congo and in Bosnia where increased demand for prostitution and forced labor caused by foreign peacekeeping troops and humanitarian aid workers accelerated the exploitation of already vulnerable populations.

There have even been reports where contractors, working on behalf of the United States Government, have contributed to, and even participated in, the trafficking of humans abroad. Nothing is more contrary to the freedoms we cherish than the trafficking of humans, which is why I introduce today the Federal Contractor Extraterritorial Jurisdiction for Human Trafficking Offenses Act.

My bill closes a loophole in U.S. criminal law. Under current law, Federal contractors who engage in human trafficking offenses abroad are subject to prosecution in the United States only if ''employed by or accompanying the Armed Forces.'' The bill closes this loophole by permitting the prosecution of Federal contractors of ''any executive agency.''

I believe all U.S. contractors should be treated the same, and all should be held to the same standards. A paycheck from the United States should never be used to purchase a human life.

I wish to point out that this legislation respects the sovereignty of foreign governments to prosecute these crimes locally. If a prosecution has occurred or is pending by the foreign government, U.S. authorities are precluded from prosecuting except upon approval of the U.S. Attorney General.

Rather, my measure authorizes the prosecution of a U.S. contractor who engages in human trafficking abroad but flees the foreign country to avoid prosecution. This happened, according to at least one report, where an employee of a Federal contractor in Bosnia bought a woman to serve as a sex slave. This individual fled the country after local authorities discovered the crime, and he returned to the U.S. to avoid prosecution. My bill would empower U.S. prosecutors to bring such an individual to justice.

Mr. President, I ask by unanimous consent that the text of my bill be printed in the RECORD.

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

S. 1226

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Contractor Extraterritorial Jurisdiction for Human Trafficking Offenses Act of 2005''.

SEC. 2. FEDERAL CONTRACTOR EXTRA-TERRITORIAL JURISDICTION.

Chapter 77 of title 18, United States Code, is amended by adding at the end the following:

''§ 1596. Federal contractor extraterritorial jurisdiction

''(a) Whoever, while a Federal contractor, engages in conduct outside the United States that would constitute a violation of this chapter punishable by imprisonment for more than 1 year if the conduct had been engaged in within the special maritime and territorial jurisdiction of the United States shall be punished as provided for that offense.

''(b) No prosecution may be commenced against a person under this section if a foreign government, in accordance with jurisdiction recognized by the United States, has prosecuted or is prosecuting such person for the conduct constituting such offense, except upon the approval of the Attorney General or the Deputy Attorney General (or a person acting in either such capacity), which function of approval may not be delegated.

''(c) An individual who is a victim of a violation of this chapter by a Federal contractor may bring a civil action against the perpetrator under section 1595 if a civil action would have been authorized under section 1595 had the conduct been engaged in within the special maritime and territorial jurisdiction of the United States.

''(d) As used in this section, the term 'Federal contractor' means a person who—

''(1) is employed as a contractor (including a subcontractor at any tier), or as an employee of a contractor (or subcontractor at any tier), of any executive agency, as that term is defined in section 4(1) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(1));

''(2) is present or residing outside the United States in connection with such employment; and

''(3) is not a national of or ordinarily resident in the country where the violation occurred.''.

By Ms. STABENOW (for herself and Ms. SNOWE):

S. 1227. A bill to improve quality in health care by providing incentives for adoption of modern information technology; to the Committee on Finance.

Mrs. STABENOW. Mr. President, I am very pleased to introduce the ''Health Information Technology Act of 2005'' with my friend and colleague from Maine, Senator Snowe. This legislation will reduce costs for our businesses, improve systems for our providers, and improve quality of care for patients.

We know we need to reduce health care costs in this country. In 2004, United States national health expenditures, known as NHEs, amounted to $1.8 trillion, or about $6,300 per person, accounting for 15.8% of our GDP. This is almost twice the average among European Union countries.

And costs are expected to continue to skyrocket. The Center for Medicare and Medicaid Services, CMS, estimates that by 2013, NHEs in the United States will reach $3.4 trillion and account for 18.8 percent of our GDP.

It is without question that the increasing cost of employer-based health insurance hurts the global competitiveness of U.S. companies. General Motors now spends more than $1,500 per vehicle on health care costs, while their non-U.S. based competitors spend as much as $1,000 less.

Our large companies certainly aren't alone in struggling to meet the health care needs of their employees—the average member of the Small Business Association of Michigan, SBAM spends nearly $8,000 per employee per year on health insurance premiums. SBAM explains very clearly one of the reasons for these high costs: ''the way in which health care information is communicated is expensive, inefficient, and many times simply does not happen.''

The members of the Health Information Technology Leadership Panel, convened pursuant to the National Coordinator for Health Information Technology's Framework for Strategic Action, recently agreed that ''increasing health care costs pose a great and growing challenge to their industries and the broader U.S. economy..''.

But it's not just the level of health care spending—at the same time that we are spending twice as much as many other countries, 45 million of our citizens lack health insurance, and a recent national study by RAND suggests that U.S. adults receive only 55 percent of recommended care.

The answer is not to cut payments or to ask patients to take less care, but to ensure the right information is where it needs to be at the time it needs to be there so that providers can give the best possible treatment and care. That will both reduce costs and improve quality of care.

However, most of our Nation's health care providers don't have access to information technology and services because it's hard enough just to keep up with their daily costs, much less to invest in something new.

And, there's another reason providers haven't been quick to adopt these systems. The nature of our health care system means that in large part the value of these technologies—through the lower costs they will achieve—accrue to the payers of health care, rather than to the providers.

The costs of necessary information not being available are great. Too often, care is duplicated like an x-ray given twice, because an emergency room doctor didn't have the results of an earlier x-ray, or the best and most appropriate care isn't given. Our health care professionals can't possibly provide the best care if they don't have complete and accurate information about the patient sitting in front of them.

Multiple studies have found that as much as $300 billion is spent each year on health care that does not improve patient outcomes on treatment that is unnecessary, inappropriate, inefficient, or ineffective.

A March 2001 Institute of Medicine, IOM, study concluded that in order to improve quality, there must be a national commitment to building an information infrastructure. An October 2003 Government Accountability Office report found that the benefits of an electronic healthcare information system included improved quality of care, reduced costs associated with medication errors, more accurate and complete medical documentation, more accurate capture of codes and charges, and improved communication among providers enabling them to respond more quickly to patients' needs.

By providing the most appropriate care at the most appropriate time, we can reap huge savings. A January 2005 Report by the Center for Information Technology Leadership, CITL, found that moving to standardized health information exchange and interoperability would save nearly $80 billion annually in the United States.

The benefits of adoption and use of health care information technologies, systems and services will be widespread: employers will realize cost savings, clinicians will gain new electronic support tools and patient information to help guide medical decisions, and patients will benefit from a more efficient health care system and from a safer health care system with fewer unnecessary treatments and more attention to preventive care. And, taxpayers and our federal programs will benefit. Researchers have suggested that up to 30 percent of annual Medicare health care spending could be saved by eliminating unnecessary and duplicative procedures, and improving quality by eliminating errors.

The benefits of health information technologies and services become most compelling on an individual level. I met an extraordinary woman just a month ago. Renae Wallace, a small business owner in Kingsley, MI told me about her son Randall. Randall is just about to turn 8, but because he was born with complex heart and lung defects, he has seen the inside of a surgery room more times than most people see in a lifetime.

Renae takes her son to providers in Traverse City, Grand Rapids, and Ann Arbor. But because there is no way for these providers to talk to each other, she has to carry around a file two inches thick of medical records—X-rays, MRI scans, surgical notes—on Randall. Otherwise, the health care professionals who are taking care of Randall wouldn't have the benefit of the results of the treatment that Randall has gotten previously. Because they wouldn't have all the information they need, Randall might not get the most appropriate care. Renae has made sure that all of the providers taking care of her son have as much of the information as possible—but it would make a lot more sense if the doctors and hospitals and nurses were able to

have that information without Renae having to carry it around.

We need to ensure that our health care professionals have all of the relevant clinical information available to them in whatever setting a patient needs care, at the time the patient needs the care so that they can provide the best and most appropriate treatment possible. We know that adoption of health information technology can play a critical role in improving patient outcomes and at the same time greatly reduce costs. But it can't happen without the federal government playing a role.

The members of the Health Information Technology Leadership Panel concurred that without Federal leadership, neither their individual companies nor the industrial sector as a whole can achieve the breadth of HIT adoption that would be required to realize the needed transformation of health care.

The bill that Senator SNOWE and I are introducing recognizes that both Federal leadership and Federal investment are necessary and appropriate. The focus of the investment provided by the ''Health Information Technology Act of 2005'' is on improving health care for patients with heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, asthma, and other diseases and conditions by driving transformation of systems in physician offices and other health care settings. Our bill includes a number of funding incentive approaches intended to improve health care through adoption of information technology.

First, we create a 5-year, $4 billion competitive grant program for hospitals, physicians, skilled nursing facilities, community health centers and community mental health centers to offset investments in new technologies and information services. Importantly, the grant program is funded by a mandatory appropriation from the Medicare trust funds. This is critical to ensuring that funds will actually be available for the grant program. It also makes sense as the trust funds will see savings through lower outlays due to less duplicative and unnecessary care.

The grant program would authorize funding for the: purchase, lease, and installment of computer software and hardware and related services; upgrade of existing computer technology; purchase communications capabilities necessary for clinical data access, storage, and exchange; services associated with acquiring, implementing, operating, or optimizing the use of new or existing computer software and hardware and clinical health care informatics systems; provision of education and training for staff on information systems and technology designed to improve patient safety; and purchase, lease, subscription, integration service of clinical decision support tools that provide ongoing continuous quality improvement functions.

Second, we allow accelerated depreciation of qualified health care information system expenditures in 2005–2010.

Third, we adjust Medicare payments to providers who use HIT that improves the quality and accuracy of clinical decision-making. We begin by addressing payments for treatment of Medicare beneficiaries with heart disease, cancer, stroke, diabetes, and chronic obstructive pulmonary disease because we know these conditions consume a large portion of our Medicare resources.

We know that the Medicare program will reap the benefit of providers using health information networks. The Office of the National Coordinator for Health Information Technology said on March 2 of this year that the annual savings attributable to widespread electronic health record adoption are likely to lie between 7.5 percent–30 percent of annual health care spending.

It only makes sense to establish new payment codes to account for the costs of purchasing and using health information technology and services with patient-specific applications.

Our legislation also will make it much easier for physicians and other health care professionals to treat patients by reducing the communication barriers that currently exist. The ''Health Information Technology Act'' provides that the Secretary shall adopt data standards for interoperability between providers and links funding to the adoption of those standards.

We know that electronic health care information systems can reap huge benefits. The GAO found these systems improve quality of care, reduce costs and improve communication among providers.

But we also know that we can't expect our health care providers to make this investment alone as they struggle to meet their daily needs. Our country must have a national commitment to building an information infrastructure, and the Federal Government needs to step up to the plate and provide much-needed funds to get the ball rolling.

We could only have dreamed about clinical computerized information systems when the Medicare and Medicaid programs began. Today, we have them at our disposal. The sooner we get them into our hospitals, physician offices, nursing homes, community health centers and community mental health centers, the sooner our patients, providers, and pocketbooks will see the rewards.

I am very pleased to announce the support of the following organizations: American College of Physicians, Federation of American Hospitals, National Council for Community Behavioral Healthcare, the National Association of Children's Hospitals, American Heart Association, National Rural Health Association, National Business Coalition on Health, American Academy of Family Physicians, National Association of Community Health Centers, American Health Care Association, IBM, Health Vision, Healthcare Information and Management Systems Society, eHealth Initiative, AdvaMed, American Health Information Management Association, Verizon, Altarum, Michigan Health and Hospital Association, Automation Alley, Small Business Association of Michigan, Detroit Chamber, Michigan State Medical Society, Detroit Medical Center, Marquette General Health System, Oakwood Healthcare System, Henry Ford Health System, MPRO, Michigan's Medicare Quality Improvement Organization; Microsoft Corporation, Axolotl Corp, Delmarva Foundation, Dell Inc, DiagnosisOne, Greenway Medical Technologies, HealthInsight, Healthgate, Inland Northwest Health Services, Kyrptiq, Lumetra, Medical Review of North Carolina, Misys Healthcare Systems, National Alliance for Primary Care Informatics, Partners Healthcare System, Siemens Corporation, Philips Medical Systems, WebMD Corporation, and the Virgin Islands Medical Institute.

I am also very pleased to have the support of the AFL–CIO, Trinity Health, NextGen, The Society of Thoracic Surgeons, American Association of Homes and Services for the Aging, St. John Health, Michigan Primary Care Association, the American Health Quality Association, and Comtek and look forward to receiving their forthcoming letters.

I ask unanimous consent to have the text of the bill and additional material printed in the RECORD.

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

AMERICAN ACADEMY
OF FAMILY PHYSICIANS,
Washington, DC, June 9, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.
Hon. OLYMPIA SNOWE,
U.S. Senate,
Washington, DC.

DEAR SENATORS STABENOW AND SNOWE: On behalf of It he 94,000 members of the American Academy of Family Physicians, congratulations on the introduction of the Health Information Technology Act. The AAFP strongly supports this legislation and we would be pleased to help you in your efforts to have Congress pass it.

The legislation recognizes that the main obstacles to widespread adoption of electronic health record systems are the significant up-front costs and the lack of general interoperability of many fragmented electronic systems. In the first case. the estimated costs of about $25,000 per physician to purchase an electronic health record system is a serious problem for family physicians in small practices that have very tight financial margins in which to operate. In the second case, even if the financing is available, a family physician will be reluctant to invest in health information technology that cannot communicate with a nearby lab or the specialist across town.

By helping physicians with the financing of these systems and by facilitating the development of interoperability standards, your legislation would go a long way to improving the quality and efficiency of health care delivery in this county.

Thank you for your leadership in this effort. We are committed to working with you

to secure passage of this important legislation.

Sincerely,

MICHAEL FLEMING,
Board Chair.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.,
Bethesda, MD, June 13, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW, On behalf of health centers all across the country and the 15 million Americans who rely on them for health care, I want to express our strong support for the ''Health Information Technology Act of 2005.'' The legislation would help to ensure that health centers have the additional resources they need to further harness the potential of information technology to improve the overall quality of health care delivered to patients in underserved communities.

Health centers recognize the value of healthcare information technology in facilitating the delivery of cost-effective, quality health care services. Indeed, through participation in the Health Resources and Services Administration's Health Disparities Collaboratives, health centers have demonstrated reductions in disparities and improved access to services through the use of electronic patient registries. However, the high cost of establishing these IT. systems throughout the entire health center is a significant barrier for centers with few financial resources.

With that in mind, NACHC applauds you for including health centers as eligible recipients of competitive grant funding and tax incentives for the design and installation of new healthcare IT systems, the upgrade of existing computer hardware and software, and training and education of health center staff. We also appreciate that your legislation would require the establishment of national healthcare IT standards that promote the interoperability of health care information across all health care settings within 2 years.

Thank you once again for introducing the ''Health Information Technology Act of 2005.'' We stand ready to work with you to advance this vital legislation in the 109th Congress.

Sincerely,

DANIEL R. HAWKINS, Jr.,
Vice-President for Federal, State, and Public Affairs.

AMERICAN HEALTH CARE ASSOCIATION,
Washington, DC, June 10, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW: On behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), the nation's largest association representing providers of quality long term care, I am writing to acknowledge our support for the ''Health Information Technology Act of 2005.''

This legislation, which you will soon introduce, has the potential to transform health and long term care by utilizing information technology to allow for the seamless transfer of health data while guaranteeing privacy and security. By creating incentives for providers to acquire health information technology and ensuring interoperability, you are taking critically important steps to improve patient safety and quality. With provisions such as allowing accelerated depreciation of qualified health care information system expenditures, you've clearly fast tracked the potential of this legislation reaching its ultimate goals.''

Senator Stabenow, AHCA and NCAL fully support and commend you for the leadership you are providing with the introduction of the ''Health Information Technology Act of 2005.''

Sincerely,

HAL DAUB,
President & CEO.

IBM
Washington, D.C., June 9, 2005.

Hon. OLYMPIA SNOWE,
U.S. Senate,
Washington, D.C.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, D.C.

DEAR SENATORS SNOWE AND STABENOW: On behalf of IBM, I would like to congratulate you on the introduction of the ''Health Information Technology Act of 2005, and we support its passage.

The Act includes number of funding incentive approaches intended to stimulate healthcare improvements enabled by information technology. Most important, the Act would adjust Medicare payments to providers who participate in a health information network that improves the quality and accuracy of clinical decision-making. With so many Americans in this one program, creating rewards for quality in Medicare will have a lifesaving impact for patients throughout the country.

The Act also authorizes grants for information technology software, hardware, and services to improve quality in health care and patient safety. Eligible grantees would include hospitals, skilled nursing facilities, federally qualified health centers, physicians, and physician group practices. Funding would be authorized for the years 2006 to 2010 as part of the Medicare program as permitted within the Budget Reserve Fund enacted in the 2006 Budget Resolution.

The legislation would also reduce the communication barriers that make it difficult for physicians to treat patients. The Act provides that the Secretary shall adopt data standards for interoperability between providers and links funding to the adoption of those standards. At the same time, the Act would implement procedures for the Secretary to accept the optional submission of data derived from health care reporting requirements. The funding will allow providers to adopt technology with standards that promote the efficient exchange of data.

Finally, the Act would amend the Internal Revenue Code to permit the expensing of health care informatics systems that meet standards adopted by the Secretary of HHS.

We thank you for advancing these important Medicare-related provisions and look forward to supporting the Act's passage this Congress.

Sincerely,

CHRISTOPHER CAINE,
Vice President, Government Programs.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

Hon. OLYMPIA SNOWE,
U.S. Senate,
Washington, DC.

DEAR SENATORS STABENOW AND SNOWE: Healthvision, Inc. is dedicated to providing and supporting connected healthcare communities where information can be securely shared among, physicians, patients, consumers, hospitals and other interested constituents in the healthcare landscape. We congratulate you both for introducing The Health Information Technology Act. This legislation would provide grants to physicians, hospitals and skilled nursing facilities for purposes of improving patient safety and reducing medical errors.

We understand the positive role that health information technology (HIT) can play in promoting safety and the quality of care. We also are cognizant that financial barriers prevent physicians and patients from receiving and utilizing health information technology that is important to reducing medical errors and creating efficiencies in the healthcare system. The Health Information Technology Act (HIT Act) provides a solution to overcoming the barriers that prevent the use and utilization of HIT to improve healthcare. By providing incentives for providers to adopt HIT, promoting the adoption of national data and health communication standards to facilitate interoperability, leveraging federal investments in Medicare and Medicaid and creating special set asides for certain groups including rural providers and health professional shortage areas, the HIT Act provides considerable leverage to help build momentum in improving healthcare as we know it today.

Quality and safety challenges, according to the Institute of Medicine, cause an estimated 44,000 to 98,000 deaths yearly due to medical errors. Legislation to adopt HIT is essential to improving healthcare by replacing antiquated paper records with electronic patient records that can be shared across healthcare communities and among the necessary stakeholders in such communities.

The Healthcare Information Act of 2005 would be an important step toward addressing some of the quality and safety challenges identified by the Institute of Medicine. It is our belief that upfront investment in HIT will improve the quality of care, while returning savings through reductions in clinical and administrative costs over time.

We applaud your leadership and look forward to working with you to provide incentives for adoption of modern health information technology to improve the quality of healthcare.

Very truly yours,

SCOTT DECKER,
President and Chief Executive Officer.

JONATHAN TEICH,
Sr. Vice President and Chief Medical Officer.

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eHEALTH INITIATIVE,
Washington, DC, June 9, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

Hon. OLYMPIA SNOWE,
U.S. Senate,
Washington, DC.

DEAR SENATORS STABENOW and SNOWE: The eHealth Initiative and the eHealth Initiative Foundation, a multi-stakeholder consortium dedicated to driving improvement in the quality, safety, and efficiency of healtcare through information and information technology, congratulate you for introducing The Health Information Technology Act of 2005. This legislation would provide grants to physicians, hospitals and skilled nursing facilities for purposes of improving patient safety and reducing medical errors.

The Health Information Technology Act of 2005 recognizes the key role played by health information technology (HIT) to improve healthcare by providing incentives for providers to adopt HIT, promoting the adoption of national data and health communication standards to facilitate interoperability, leveraging federal investments in Medicare and Medicaid and creating special set asides for certain groups including rural providers and health professional shortage areas.

Legislation to encourage the adoption of health information technology to improve healthcare quality is essential, given that 90 percent of the 30 billion U.S. health transactions each year are conducted by phone, fax or mail and only 15 percent of US physicians use electronic health records. These quality and safety Challenges according to the Institute of Medicine, cause an estimated 44,000 to 98,000 deaths yearly due to medical errors.

Various studies have shown the potential of health information technology to make improvements in healthcare quality. For example, a rural community hospital prevented administration of over 1,200 wrong drugs or dosages using automatic identification technology and wireless scanners to verify both the identities of patients and their correct medications (GAO–04–224).

The Health Information Technology Act of 2005 would be an important step toward addressing some of the quality and safety challenges identified by the Institute of Medicare. It is our belief that upfront investment in HIT will improve the quality of care, while returning savings through reductions in clinical and administrative cots over time.

On behalf of the undersigned and other members of the eHealth Initiative, we salute your leadership and look forward to working with you to provide incentives for adoption of modern health information technology to improve the quality of healthcare.

Sincerely,

AdvaMed.
American College of Physicians.
American Health Information Management Association.
Altarum Institute.
Axolotl Corp.
Delmarva Foundation.
Dell Inc.
DiagnosisOne.
Federation of American Hospitals.
Healthcare Information and Management Systems Society.
Greenway Medical Technologies.
HealthInsight.
Healthgate.
Healthvision.
IBM.
Inland Northwest IHealth Services.
Kryptiq.
Lumetra.
Medical Review of North Carolina.
Microsoft Corporation.
Misys Healthcare Systems.
National Alliance for Primary Care Informatics.
National Business Coalition on Health.
Partners Healthcare System.
Siemens Corporation.
Philips Medical Systems.
WebMD Corporation.

HIMSS®
Chicago, IL, June 9, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.
Hon. OLYMPIA SNOWE,
U.S. Senate,
Washington, DC.

DEAR SENATORS STABENOW AND SNOWE: On behalf of the Healthcare Information and Management Systems Society and our 15,000 individual and over 260 corporate members and 45 chapters nationwide, we are pleased to support the Health Information Technology Act of 2005. HIMSS members are very aware of the need for catalyst legislation to improve patient safety and cost effective healthcare in the U.S. Legislation like the Health Information Technology Act of 2005 provides the type of congressional leadership that will improve healthcare delivery for the nation.

HIMSS supports the concepts of this legislation because it represents a positive step forward in the national agenda to provide a catalyst to encourage substantial investments into information technology and management systems to improve the quality, safety, and efficiency of patient care. Through our members and the Society's advocacy outreach, we will continue to support and work for the bill's passage.

We are particularly encouraged by the provisions in the legislation to create a grant program to infuse almost $4 billion in federal funding into the provider community to encourage adoption of information systems and services, as well as the emphasis on interoperability that address the needs of providers in diverse geographic settings, including setting aside at least 20 percent for rural communities.

The HIMSS Board of Directors applauds your efforts in realizing and acting on the need for infuse federal funding into the provider community to adopt much needed information technology.

We look forward to working with you to gain additional healthcare industry support for the legislation. If we can be of any further assistance, please contact Mr. Dave Roberts, HIMSS Director of Public Policy.

Sincerely,

H. STEPHEN LIEBER,
President & CEO.
PAMELA R. WIRTH,
Chairperson of the Board, HIMSS, Vice President, Soarian Medical Solutions, Siemens Medical Systems.

VERIZON,
Washington, DC, June 13, 2005.

Senator OLYMPIA J. SNOWE,
Senator DEBBIE A. STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATORS SNOWE AND STABENOW: On behalf of Verizon, I applaud your introduction of the Health Information Technology Act of 2005. This legislation recognizes the vital role of information technology im making a difference in improving quality and reducing the cost of health care, both of which are important to Verizon, as well as the Nation. Verizon has a vital stake in seeing improvements in the health care system, as we provide health care coverage for over 800,000 employees, retirees and their dependents. We hope the health care system can benefit from the technologies that have worked so well in transforming our industry.

In particular, we appreciate your recognition of telecommunications technology and its significance in improving quality and patient safety. Verizon believes that broadband, wireless and other telecommunications services can also make a real difference in reducing barriers and improving access to quality health care. We look forward to working with you in passing this important piece of legislation to improve the health care system.

ANDREW M. MEKELBURG,
Vice President,
Federal Government Relations.

ALTARUM,
Ann Arbor, MI, June 5, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW: I am writing to convey to you Altarum Institute's strong support for the Health Information Technology Act, which you are about to introduce into the United States Senate.

As you well know, Altarum is now helping the state of Michigan to define, develop and deploy the Michigan Health Information Network—the underlying technical, standards and governance foundation that will ensure that promising health information technology efforts across the state are both interoperable and sustainable.

While with the MHIN we help to prepare the ''foundation'' upon which these health IT applications will rest, your bill takes a tremendous stride forward in helping healthcare providers actually make these health IT tools a part of how they do their business. We sincerely hope and trust that providers who, due to the grant programs envisioned in your bill, can begin to see their way clear to adopting health IT tools in their practices will be ready to work as part of a broader community to ensure interoperability, common standards and a governing model such as the MHIN will provide.

Your leadership in this critically important area is both timely and appreciated. We look forward to consideration and passage of the Health Information Technology Act.

Sincerely,

KENNETH R. BAKER,
President.

MICHIGAN HEALTH
& HOSPITAL ASSOCIATION,
Lansing, MI, June 8, 2005.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW, The Michigan Health & Hospital Association welcomes your efforts to assist with the capital investment requirements hospitals face for health information technology. The MHA supports your pending legislation, The Health Information Technology Act of 2005, which would provide needed funding for new health IT design, purchase and collaboration, as well as recognition of these costs within the Medicare reimbursement system. This issue will continue to develop in importance for Michigan hospitals and we look forward to working with you to identify how best to provide federal assistance for technology infrastructure, while keeping patient-focused safety and quality improvement as the primary goal for all concerned.

Thank you for your continued support. I may be reached at 517/703–86009 if you would like to discuss this matter in further detail.

Sincerely,

BRIAN PETERS,
Senior Vice President, Advocacy.

Ms. SNOWE. Mr. President, today I join my colleague, Senator STABENOW of Michigan, in introducing the ''Health Information Technology Act of 2005'', which will serve to improve the quality of health care through implementation of information technology; IT, in hospitals, health centers and physician practices throughout the country. At a time when the Institute of Medicine (IOM) has reported that up to 98,000 Americans die each year due to medical errors, we cannot afford to wait. When we also consider the escalating cost of health care in this country, we must recognize that this level of growth in spending has created a crisis. Information technology is one solution, and this legislation will assert the federal government's role in providing leadership in this area and provide financial incentives to spur rapid adoption of information technology in medicine. Our legislation is necessary because as a nation we face two stark problems.

The first of these is a serious patient safety problem. The good news is that solutions exist: We have the technological ability to dramatically reduce medical errors and thus save lives. Many have heard about how drug interactions can be avoided by software systems which check a patient's prescriptions for hazards. Yet there are so many other applications which can improve health. For example, by reviewing and analyzing information, a health provider can help a patient better manage chronic diseases such as diabetes and heart disease, and avoid adverse outcomes.

Our second major problem is the escalating cost of health care. Costs are reduced when tests don't have to be repeated and data isn't delayed. In fact, a patient may obtain faster, higher quality care when, for example, multiple practitioners can review diagnostic test results right at their desktops. In an age where millions of Americans share family pictures over the internet in seconds, isn't it long past time that a physician should be able to retrieve an x-ray just as easily?

The President certainly recognizes the disparity in technology in health versus other parts of our economy. He has declared a goal for every American to have an electronic medical record within 10 years. I concur—we need this and more. In fact, once that record is in place we can do so many things better. From preventing drug interactions, to managing chronic diseases, to simply helping providers operate more efficiently. Most of us have been told at one time or another, ''we're waiting to get the test results mailed'', or ''we're still waiting for your chart''. Health care is one of the last bastions of such inefficiency.

The bad news is that high start-up costs and a lack of standards have prevented us from reaping the benefits of new technologies. I am certainly looking forward to the progress we will make with Dr. David Brailer heading the new Office of the National Coordinator for Health Information Technology at the Department of Health and Human Services. The President has made technology implementation a priority, and there is no doubt that a lack of standards has prevented IT adoption by many health care providers. One must know that a system purchased will be compatible with others, and that—no matter what may happen in the future to a vendor—the huge investment one makes in building an electronic medical record won't be lost. In other words, your system must be able to communicate with other systems, and your investment in building electronic medical records must be preserved. So when a patient moves, their electronic ''chart'' should be able to move right along with them, and their continuity of care shouldn't be interrupted.

Yet standards alone aren't enough. Today many providers are struggling to make these investments, and for those which serve beneficiaries of Medicare, Medicaid and SCHIP, it can be exceedingly difficult.

The legislation which we are introducing today will bring the solution within our reach. In the last Congress I worked with Senator BOB GRAHAM to introduce legislation which provided a grants program to give assistance to hospitals and long term care facilities to enable investment in IT. As I join today with Senator STABENOW to introduce this legislation, we have made several crucial enhancements to the previous bill. The legislation now includes both federally-qualified health centers and community mental health centers as eligible to receive IT grants. In addition, physician practices can also participate. All three are key treatment environments where both costs and errors must be addressed.

Our new legislation even provides an alternative to those for-profit providers who do not wish to apply for a grant. Under this bill, such providers will be able to expense the cost of a qualified system.

The legislation supports expenditures for a variety of expenses required to implement health care information technology. These include such components as computer hardware and software, plus installation and training costs. In addition, when installed we require that every system must meet the HHS Secretary's interoperability standards.

We know we will realize significant savings through information technology. On that there is bipartisan consensus. Yet as providers are facing even declining payment rates, they also are told they must institute changes in the way they practice, including implementing information technology. We know that much of the savings in health care IT will accrue to the patient and payer—in such aspects as fewer duplicate tests, greater efficiency, and better health management. Thus it is appropriate that the Federal Government would assist with the often prohibitive start-up costs—particularly for those who serve beneficiaries of Medicare, Medicaid and SCHIP.

I again want to stress the first goal of this legislation: To help build a safer medical-delivery system. The great successes of our health care system are largely due to our highly committed and talented health care professionals. The problem we are addressing today is not theirs, but is an endemic weakness of the system they depend upon. However, to utilize the solution, the Federal Government must step forward and provide the leadership necessary to make system changes a reality.

When the Medicare and Medicaid programs began, we could only have dreamed about computerized clinical information systems. Now, today, we have this technology at our disposal, and I strongly believe that we cannot afford to delay implementation. I hope my colleagues will join us in support of this legislation so we may soon achieve the goals of improving patient safety and reducing our escalating health care costs.

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

S. 1227

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Information Technology Act of 2005''.

SEC. 2. INFORMATICS SYSTEMS GRANT PROGRAM.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program to award grants to eligible entities that have submitted applications in accordance with subsection (b) for the purpose of assisting such entities in offsetting the costs incurred after December 31, 2004, that are related to clinical health care informatics systems and services designed to improve quality in health care and patient safety.

(2) DURATION.—The authority of the Secretary to make grants under this section shall terminate on September 30, 2010.

(3) COSTS DEFINED.—For purposes of this section, the term ''costs'' shall include total expenditures incurred for—

(A) purchasing, leasing, and installing computer software and hardware, including handheld computer technologies, and related services;

(B) making improvements to existing computer software and hardware;

(C) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange;

(D) services associated with acquiring, implementing, operating, or optimizing the use of new or existing computer software and hardware and clinical health care informatics systems;

(E) providing education and training to eligible entity staff on information systems and technology designed to improve patient safety and quality of care; and

(F) purchasing, leasing, subscribing, integrating, or servicing clinical decision support tools that—

(i) integrate patient-specific clinical data with well-established national treatment guidelines; and

(ii) provide ongoing continuous quality improvement functions that allow providers to assess improvement rates over time and against averages for similar providers.

(4) ELIGIBLE ENTITY DEFINED.—For purposes of this section, the term ''eligible entity'' means the following entities:

(A) HOSPITAL.—A hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))).

(B) CRITICAL ACCESS HOSPITAL.—A critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

(C) SKILLED NURSING FACILITY.—A skilled nursing facility (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(D) FEDERALLY QUALIFIED HEALTH CENTER.—A Federally qualified health center (as defined in section 1861(aa)(4) of such Act (42 U.S.C. 1395x(aa)(4))).

(E) PHYSICIAN.—A physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r))).

(F) PHYSICIAN GROUP PRACTICE.—A physician group practice.

(G) COMMUNITY MENTAL HEALTH CENTER.—A community mental health center (as defined

in section 1861(ff)(3)(B) of such Act (42 U.S.C. 1395x(ff)(3)(B))).

(b) APPLICATION.—

(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Secretary at such time, in such form and manner, and containing the information described in paragraph (2).

(2) INFORMATION DESCRIBED.—The information described in this paragraph is the following information:

(A) A description of—

(i) the clinical health care informatics system and services that the eligible entity intends to implement with the assistance received under this section; and

(ii) how the system will improve quality in health care and patient safety, including estimates of the impact on the health of, and the health costs associated with the treatment of, patients with heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, asthma, or any other disease or condition specified by the Secretary.

(B) Any additional information that the Secretary may specify.

(c) PRIORITY FOR CERTAIN ELIGIBLE ENTITIES.—In awarding grants under this section, the Secretary shall give priority—

(1) first, to eligible entities—

(A) that are exempt from tax under section 501(a) of the Internal Revenue Code of 1986; and

(B)(i) in which the total of individuals that are eligible for benefits under the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, or under the State children's health insurance program under title XXI of such Act make up a high percentage (as determined appropriate by the Secretary) of the total patient population of the entity; or

(ii) that provide services to a large number (as determined appropriate by the Secretary) of such individuals;

(2) then, to eligible entities that meet the requirement under clause (i) or (ii) of paragraph (1)(B); and

(3) then, to other eligible entities.

(d) RESERVE FUNDS FOR ENTITIES IN HEALTH PROFESSIONAL SHORTAGE AREAS OR RURAL AREAS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall ensure that at least 20 percent of the funds available for making grants under this section to—

(A) hospitals and critical access hospitals are used for making grants to such hospitals that are located exclusively in an applicable area;

(B) skilled nursing facilities are used for making grants to such facilities that are located exclusively in an applicable area;

(C) Federally qualified health centers are used for making grants to such centers that are located exclusively in an applicable area;

(D) physicians and physician group practices are used for making grants to physicians and such practices that are located exclusively in an applicable area; and

(E) community mental health centers are used for making grants to such centers that are located exclusively in an applicable area.

(2) AVAILABILITY OF RESERVE FUNDS IF LIMITED NUMBER OF ENTITIES APPLY FOR RESERVED GRANTS.—If the Secretary estimates that the amount of funds reserved under subparagraph (A), (B), (C), (D), or (E) of paragraph (1) for the type of entity involved exceeds the maximum amount of funds permitted for such entities under subsection (e), the Secretary may reduce the amount reserved for such entities by an amount equal to such excess and use such funds for awarding grants to other eligible entities.

(3) APPLICABLE AREA DEFINED.—For purposes of paragraph (1), the term ''applicable area'' means—

(A) an area that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act;

(B) a rural area (as such term is defined for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))); or

(C) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(e) AMOUNT OF GRANT.—

(1) AMOUNT.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall determine the amount of a grant awarded under this section.

(B) CONSIDERATION.—In determining the amount of a grant under this section, the Secretary shall take into account the ability to take an expense deduction for health care informatics system expenses under section 179C of the Internal Revenue Code of 1986, as added by section 5.

(2) LIMITATION.—

(A) IN GENERAL.—A grant awarded under this section may not exceed the lesser of—

(i) an amount equal to the applicable percentage of the costs incurred by the eligible entity for the project for which the entity is seeking assistance under this section; or

(ii) in the case of a grant made to—

(I) a hospital or a critical access hospital, $1,000,000;

(II) a skilled nursing facility, $200,000;

(III) a Federally qualified health center, $150,000;

(IV) a physician, $15,000;

(V) a physician group practice, an amount equal to $15,000 multiplied by the number of physicians in the practice; or

(VI) a community mental health center, $75,000.

(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A)(i), the term ''applicable percentage'' means, with respect to an eligible entity for the period involved, the percentage of total revenues (excluding grants and gifts from Federal, State, local government, and private sources) for such period that consists of total revenues from the medicare program, the medicaid program, and the State children's health insurance program under titles XVIII, XIX, and XXI, respectively, of the Social Security Act.

(f) REQUIREMENTS.—

(1) COMPLIANT WITH STANDARDS.—A clinical health care informatics system funded under this section and placed in service on or after the date the standards are adopted under section 4 shall be compliant with such standards.

(2) FURNISHING THE SECRETARY WITH INFORMATION.—

(A) IN GENERAL.—An eligible entity receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

(i) evaluate the project for which the grant is made; and

(ii) ensure that assistance provided under the grant is expended for the purposes for which it is made.

(B) COORDINATION.—The Secretary shall ensure that the requirements for furnishing information under subparagraph (A) are coordinated with other requirements for furnishing information to the Secretary that the eligible entity is subject to.

(g) STUDIES.—The Secretary shall conduct studies to—

(1) evaluate the use of clinical health care informatics systems and services implemented with assistance under this section to measure and report quality data based on accepted clinical performance measures; and

(2) assess the impact of such systems and services on improving patient care, reducing costs, and increasing efficiencies.

(h) REPORTS.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—The Secretary shall submit, at least annually, a report to the appropriate committees of Congress on the grant program established under this section.

(B) CONTENTS.—A report submitted pursuant to subparagraph (A) shall include information on—

(i) the number of grants made;

(ii) the nature of the projects for which assistance is provided under the grant program;

(iii) the geographic distribution of grant recipients;

(iv) the impact of the projects on the health of, and the health costs associated with the treatment of, patients with heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, asthma, or any other disease or conditions specified by the Secretary;

(v) the results of the studies conducted under subsection (g); and

(vi) such other matters as the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than 180 days after the completion of all of the projects for which assistance is provided under this section, the Secretary shall submit a final report to the appropriate committees of Congress on the grant program established under this section, together with such recommendations for legislation and administrative action as the Secretary determines appropriate.

(i) FUNDING.—

(1) HOSPITALS.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $250,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are hospitals or critical access hospitals.

(2) SKILLED NURSING FACILITIES.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $100,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are skilled nursing facilities.

(3) FEDERALLY QUALIFIED HEALTH CENTERS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $40,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are Federally qualified health centers.

(4) PHYSICIANS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $400,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are physicians or physician group practices.

(5) COMMUNITY MENTAL HEALTH CENTERS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) $20,000,000, for each of the fiscal years 2006 through 2010, for the purpose of making grants under this section to eligible entities that are community mental health centers.

SEC. 3. ADJUSTMENTS TO MEDICARE PAYMENTS FOR HEALTH INFORMATION TECHNOLOGY ENABLED QUALITY SERVICES.

(a) ADJUSTMENTS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a methodology for making adjustments in payment amounts under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) made to providers of services and suppliers who—

(1) furnish items or services for which payment is made under such title; and

(2) in the course of furnishing such items and services, use health information technology and technology services with patient-specific applications that the Secretary determines improves the quality and accuracy of clinical decision-making, compliance, health care delivery, and efficiency, such as electronic medical records, electronic prescribing, clinical decision support tools integrating well-established national treatment guidelines with continuous quality improvement functions, and computerized physician order entry with clinical decision-support capabilities.

(b) REQUIREMENTS.—The methodology established under subsection (a) shall—

(1) include the establishment of new codes, modification of existing codes, and adjustment of evaluation and management modifiers to such codes, that take into account the costs of acquiring, using, and maintaining health information technology and services with patient-specific applications;

(2) first address adjustments for payments for items and services related to the diagnosis or treatment of heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease (COPD), and other diseases and conditions that result in high expenditures under the medicare program and for which effective health information technology exists; and

(3) take into account estimated aggregate annual savings in overall payments under such title XVIII attributable to the use of health information technology and services with patient-specific applications.

(c) DURATION.—The Secretary may reduce or eliminate adjustments made to payments pursuant to subsection (a) as payment methodologies under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are adjusted to reflect provider quality and efficiency.

(d) RULE OF CONSTRUCTION.—In making national coverage determinations under section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) with respect to maintaining health information technology and services with patient-specific applications, in determining whether the health information technology and services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, the Secretary shall consider whether the health information technology and services improve the health of medicare beneficiaries, including the improvement of clinical outcomes or cost-effectiveness of treatment.

(e) DEFINITIONS.—In this section:

(1) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given that term under section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(2) SUPPLIER.—The term ''supplier'' has the meaning given that term under section 1861(d) of such Act (42 U.S.C. 1395x(d)).

SEC. 4. INTEROPERABILITY.

(a) DEVELOPMENT AND ADOPTION OF STANDARDS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for the development and adoption under programs administered by the Secretary of national data and communication health information technology standards that promote the efficient exchange of data between varieties of provider health information technology systems. In carrying out the preceding sentence, the Secretary may adopt existing standards consistent with standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104).

(2) REQUIREMENTS.—The standards developed and adopted under paragraph (1) shall be designed to—

(A) enable health information technology to be used for the collection and use of clinically specific data;

(B) promote the interoperability of health care information across health care settings, including reporting to the Secretary and other Federal agencies; and

(C) facilitate clinical decision support through the use of health information technology.

(b) IMPLEMENTATION OF PROCEDURES FOR THE SECRETARY TO ACCEPT DATA USING STANDARDS.—

(1) DATA FROM NEW HEALTH CARE REPORTING REQUIREMENTS.—Not later than January 1, 2008, the Secretary shall implement procedures to enable the Department of Health and Human Services to accept the optional submission of data derived from health care reporting requirements established after the date of enactment of this Act using data standards adopted under this section.

(2) DATA FROM ALL REQUIREMENTS.—

(A) IN GENERAL.—Not later than January 1, 2010, the Secretary shall implement procedures to enable the Department of Health and Human Services to accept the optional submission of data derived from all health care reporting requirements using data standards adopted under this section.

(B) LIMITATION.—

(i) IN GENERAL.—On and after January 1, 2010, if an entity or individual elects to submit data to the Secretary using data standards adopted under this section, the Secretary, subject to clause (ii), may not require such entity or individual to also submit such data in an additional format.

(ii) EXCEPTION.—The Secretary may provide for an exception, not to exceed 2 years, to the limitation under clause (i) with respect to certain types of data if the Secretary determines that such an exception is appropriate.

SEC. 5. ELECTION TO EXPENSE HEALTH CARE INFORMATICS SYSTEMS.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to itemized deductions for individuals and corporations) is amended by inserting after section 179B the following new section:

''SEC. 179C. HEALTH CARE INFORMATICS SYSTEMS EXPENDITURES.

''(a) TREATMENT OF EXPENDITURES.—

''(1) IN GENERAL.—An eligible entity may elect to treat any qualified health care informatics system expenditure which is paid or incurred by the taxpayer as an expense which is not chargeable to capital account. Any expenditure which is so treated shall be allowed as a deduction.

''(2) ELECTION.—An election under paragraph (1) shall be made under rules similar to the rules of section 179(c).

''(b) LIMITATIONS.—

''(1) DOLLAR LIMITATION.—With respect to any eligible entity, the aggregate cost which may be taken into account under subsection (a)(1) for any taxable year shall not exceed, when added to any cost taken into account under this section in any preceding taxable year, the dollar amount specified under section 2(e)(2)(A)(ii) of the Health Information Technology Act of 2005.

''(2) APPLICABLE RULES.—For purposes of this subsection, rules similar to the rules of paragraphs (3) and (4) of subsection (b) and paragraphs (6), (7), and (8) of subsection (d) of section 179 shall apply.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED HEALTH CARE INFORMATICS SYSTEM EXPENDITURES.—

''(A) IN GENERAL.—The term 'qualified health care informatics system expenditure' means, with respect to any taxable year, any direct or indirect costs incurred and properly taken into account with respect to the purchase or installation of equipment and facilities relating to any qualified health care informatics system. Such term shall include so much of the purchase price paid by the lessor of equipment and facilities subject to a lease described in subparagraph (B)(ii) as is attributable to expenditures incurred by the lessee which would otherwise be described in the preceding sentence.

''(B) WHEN EXPENDITURES TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—Qualified health care informatics system expenditures shall be taken into account under this section only with respect to equipment and facilities—

''(I) the original use of which commences with the taxpayer, and

''(II) which are placed in service after December 31, 2004, and before October 1, 2010.

''(ii) SALE-LEASEBACKS.—For purposes of clause (i), if property—

''(I) is originally placed in service after December 31, 2004, and before October 1, 2010, by any person, and

''(II) sold and leased back by such person within 3 months after the date such property was originally placed in service,

such property shall be treated as originally placed in service not earlier than the date on which such property is used under the leaseback referred to in subclause (II).

''(C) GRANTS, ETC. EXCLUDED.—The term 'qualified health care informatics system expenditure' shall not include any amount to the extent such amount is funded by any grant, contract, or otherwise by another person (or any governmental entity).

''(2) QUALIFIED HEALTH CARE INFORMATICS SYSTEM.—The term 'qualified health care informatics system' means a system which—

''(A) has been individually approved by the Secretary of Health and Human Services for purposes of this section,

''(B) consists of electronic health record systems and other health information technologies, and

''(C) meets the standards adopted by the Secretary of Health and Human Services under section 4 of the Health Information Technology Act of 2005 by not later than the date which is 60 days after the date of the adoption of such standards.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' has the meaning given such term by section 2(a)(4) of the Health Information Technology Act of 2005.

''(4) PROPERTY USED OUTSIDE THE UNITED STATES, ETC., NOT QUALIFIED.—No expenditures shall be taken into account under subsection (a)(1) with respect to the portion of the cost of any property referred to in section 50(b) or with respect to the portion of the cost of any property specified in an election under section 179.

''(5) ORDINARY INCOME RECAPTURE.—For purposes of section 1245, the amount of the deduction allowable under subsection (a)(1) with respect to any property which is of a

character subject to the allowance for depreciation shall be treated as a deduction allowed for depreciation under section 167.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 263(a)(1) of the Internal Revenue Code of 1986 (relating to capital expenditures) is amended by striking ''or'' at the end of subparagraph (H), by striking the period at the end of subparagraph (I) and inserting '', or'', and by adding at the end the following new subparagraph:

''(J) expenditures for which a deduction is allowed under section 179C.''.

(2) The table of sections for part VI of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 190 the following new item:

''Sec. 179C. Health care informatics system expenditures.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service after December 31, 2004.

SEC. 6. SENSE OF THE SENATE.

It is the sense of the Senate that the provisions of, and amendments made by, this Act should achieve deficit neutrality over the 5-year period beginning on October 1, 2005.

By Mr. REID (for himself, Mrs. FEINSTEIN, Ms. CANTWELL, Ms. SNOWE, Mr. JEFFORDS, Mr. LIEBERMAN, and Mr. KERRY):

S. 1229. A bill to amend the Internal Revenue Code of 1986 to extend, modify, and expand the credit for electricity produced from renewable resources and waste products, and for other purposes; to the Committee on Finance.

Mr. REID. Faced with uncertainties in electricity energy markets, turmoil in the Middle East, the need to cut back on the fossil fuel emissions linked to global warming, air pollution that contributes to high rates of asthma and fills even our national parks with smog, the United States must diversify its energy supply by promoting the growth of renewable energy.

Since 1999, Las Vegas electricity rates have increased by 50 percent. In the same time period, natural gas prices across Nevada rose 45 percent. We need to change the energy equation. We need to diversify the nation's energy supply to reduce volatility and ensure a stable supply of electricity. We must harness the brilliance of the sun, the strength of the wind, and the heat of the Earth to provide clean renewable energy for our Nation.

Mr. President, I rise today to introduce a bill with Senators FEINSTEIN, CANTWELL, SNOWE, JEFFORDS, LIEBERMAN and KERRY that expands the existing Section 45 production tax credit for renewable energy resources to cover all renewable energy resources. Our legislation accomplishes this by ensuring that geothermal, incremental geothermal, solar, open-loop biomass, incremental hydropower, landfill gas, and animal waste to the list of renewable energy resources that would qualify for a production tax credit.

Our legislation also makes the production tax credit permanent to signal America's longterm commitment to renewable energy resources. The existing production tax credit will expire at the end of the year. Since it inception in 1992, the production tax credit has expired and been renewed three times—in 1999, 2001, and 2004. Development of wind energy has closely mirrored these renewal cycles. Clearly, the private investment necessary to develop renewable energy resources requires the business certainty afforded by a long-term extension of the production tax credit. Our bill allows for co-production credits to encourage blending of renewable energy with traditional fuels and provides a credit for renewable facilities on Native American and Native Alaskan lands.

In northern Nevada, the Pyramid Lake Paiute Tribe is working with Advanced Thermal Systems to develop geothermal resources on Indian lands that will spur economic development by creating business opportunities and jobs for tribal members.

This legislation also provides production incentives to not-for-profit public power utilities and rural electric cooperatives, which serve 25 percent of the Nation's power customers, by allowing them to transfer their credits to taxable entities. The good news is that the production tax credit for renewable energy resources really works to promote the growth of renewable energy.

In 1990, the cost of wind energy was 22.5 cents per kilowatt hour and, today, with new technology and the help of a modest production tax credit, wind is a competitive energy source at approximately 5.5 cents per kilowatt hour. In the last 5 years, wind energy has experienced a 30 percent growth rate. The production tax credit provides 1.8 cents for every kilowatt-hour of electricity produced. Similar to wind energy, this credit will allow geothermal energy, incremental hydropower, and landfill gas to immediately compete with fossil fuels, while biomass will follow closely behind. The Department of Energy estimates that we could increase our geothermal energy production almost tenfold, supplying ten percent of the energy needs of the West. As fantastic as it sounds, enough sunlight falls on 100 square miles of southern Nevada that—if covered with solar panels—could power the entire Nation.

Let's never lose sight of the fact that renewable energy resources are domestic sources of energy, and using them instead of foreign sources contributes to our energy security. Renewables provide fuel diversify and price stability. After all, the fuel—from the wind, the sun, and heat from the core of the earth—cost nothing. And they provide jobs, especially in rural areas that have been largely left out of America's recent economic growth. The production tax credit for renewable energy resources is a powerful, fast-acting stimulus to the economy. According to the Western Governors Association, the Department of Energy's Initiative to deploy 1,000 Megawatts of concentrated solar power in the Southwestern area of the United States by the year 2006 would create approximately 10,000 jobs and estimated expenditures of more than $3.7 billion over 14 years.

Nevada has already developed 200 megawatts of geothermal power, with a longer-term potential of more than 2,500 megawatts; this development will provide billions of dollars in private investment and create thousands of jobs. Our production tax credit means immediate economic development and jobs.

In the U.S. today, we get 2 percent of our electricity from renewable energy sources like wind, solar, geothermal, and biomass. But the potential for much greater supply is here. For example, Nevada could use geothermal energy to meet one-third of its electricity needs, but today this source of energy only supplies 2 percent. I am proud to say that Nevada has adopted one of the most aggressive Renewable Portfolio Standards in the Nation, requiring 15 percent of the State's electricity needs be met by renewable energy resources in 2013.

After pouring billions of dollars into oil and gas, we need to invest in a clean energy future. Fossil fuel plants pump over 11 million tons of pollutants into our air each year. Federal energy policy must promote reductions in greenhouse gas emissions. By including landfill gas in this legislation, we systematically reduce the largest single human source of methane emissions in the United States, effectively eliminating the greenhouse gas equivalent of 233 million tons of carbon dioxide.

Medical studies have revealed an alarming link between soot particles from power plants and motor vehicles and lung cancer and heart disease. The adverse health effects of power plant and vehicle emissions cost Americans billions of dollars in medical care, and our cost in human suffering is immeasurable. Simply put, the human cost of dirty air is staggering. If we factor in environmental and health effects, the real cost of energy becomes apparent, and renewable energy becomes the fuel of choice.

America's abundant and untapped renewable resources can fuel our journey into a more prosperous and safer tomorrow without compromising air and water quality. Renewable energy is a critical component of a successful, forward-looking, and secure energy policy for the 21st Century.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1229

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

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

(a) SHORT TITLE.—This Act may be cited as the ''Renewable Energy Incentives Act''.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a

section or other provision of the Internal Revenue Code of 1986.

SEC. 2. EXTENSION, MODIFICATION, AND EXPANSION OF CREDIT FOR ELECTRICITY PRODUCED FROM RENEWABLE RESOURCES AND WASTE PRODUCTS.

(a) PERMANENT EXTENSION.—

(1) Paragraphs (1) and (2)(A)(i) of section 45(d) are each amended by striking '', and before January 1, 2006''.

(2) Section 45(d)(2)(A)(ii) is amended by striking ''before January 1, 2006, is originally placed in service and'' and insert ''is''.

(3) Section 45(d)(3)(A) is amended__

(A) by striking ''owned by the taxpayer'',

(B) by inserting ''owned by the taxpayer and'' in clause (i)(I) after ''is''

(C) by striking ''and before January 1, 2006'' in clause (i)(I), and

(D) by striking ''originally placed in service before January 1, 2006'' in clause (ii) and inserting ''owned by the taxpayer''.

(4) Paragraphs (4), (5), (6), and (7) of section 45(d) (relating to qualified facilities) are amended by striking ''and before January 1, 2006'' each place it appears.

(b) CREDIT RATE.—

(1) INCREASE IN CREDIT RATE.—

(A) IN GENERAL.—Section 45(a)(1) is amended by striking ''1.5 cents'' and inserting ''1.9 cents''.

(B) CONFORMING AMENDMENTS.—

(i) Section 45(b)(2) is amended by striking ''1.5 cent'' and inserting ''1.9 cent''.

(ii) Section 45(e)(2)(B) is amended by inserting ''(calendar year 2004 in the case of the 1.9 cent amount in subsection (a))'' after ''1992''.

(2) FULL CREDIT RATE FOR ALL FACILITIES PLACED IN SERVICE AFTER DATE OF ENACTMENT.—Section 45(b)(4)(A) (relating to credit rate) is amended by inserting ''and placed in service before the date of the enactment of the Renewable Energy Incentives Act'' after ''subsection (d)''.

(c) FULL CREDIT PERIOD FOR ALL FACILITIES PLACED IN SERVICE AFTER DATE OF ENACTMENT.—Section 45(b)(4)(B)(i) (relating to credit period) is amended by inserting ''and placed in service before the date of the enactment of the Renewable Energy Incentives Act'' after ''subsection (d)''

(d) EXPANSION OF QUALIFIED RESOURCES.—

(1) IN GENERAL.—Section 45(c)(1) (defining qualified energy resources) is amended by striking ''and'' at the end of subparagraph (F), by striking the period at the end of subparagraph (G) and inserting a comma, and by adding at the end the following new subparagraphs:

''(H) incremental geothermal energy production, and

''(I) incremental hydropower production.''.

(2) DEFINITION OF RESOURCES.—Section 45(c) (relating to qualified energy resources and refined coal) is amended by adding at the end the following new paragraphs:

''(8) INCREMENTAL GEOTHERMAL PRODUCTION.—

''(A) IN GENERAL.—The term 'incremental geothermal production' means for any taxable year the excess of—

''(i) the total kilowatt hours of electricity produced from an incremental geothermal facility described in subsection (d)(9), over

''(ii) the average annual kilowatt hours produced at such facility for 5 of the previous 7 calendar years before the date of the enactment of this paragraph after eliminating the highest and the lowest kilowatt hour production years in such 7-year period.

''(B) SPECIAL RULE.—A facility described in subsection (d)(9) which was placed in service at least 7 years before the date of the enactment of this paragraph shall commencing with the year in which such date of enactment occurs, reduce the amount calculated under subparagraph (A)(ii) each year, on a cumulative basis, by the average percentage decrease in the annual kilowatt hour production for the 7-year period described in subparagraph (A)(ii) with such cumulative sum not to exceed 30 percent.

''(9) INCREMENTAL HYDROPOWER PRODUCTION.—

''(A) IN GENERAL.—The term 'incremental hydropower production' means for any taxable year an amount equal to the percentage of total kilowatt hours of electricity produced from an incremental hydropower facility described in subsection (d)(10) attributable to efficiency improvements or additions of capacity as determined under subparagraph (B).

''(B) DETERMINATION OF INCREMENTAL HYDROPOWER PRODUCTION.—For purposes of subparagraph (A), incremental hydropower production for any incremental hydropower facility for any taxable year shall be determined by establishing a percentage of average annual hydropower production at the facility attributable to the efficiency improvements or additions of capacity using the same water flow information used to determine an historic average annual hydropower production baseline for such facility. Such percentage and baseline shall be certified by the Federal Energy Regulatory Commission. For purposes of the preceding sentence, the determination of incremental hydropower production shall not be based on any operational changes at such facility not directly associated with the efficiency improvements or additions of capacity.''.

(3) FACILITIES.—Section 45(d) (relating to qualified facilities) is amended by adding at the end the following new paragraphs:

''(9) INCREMENTAL GEOTHERMAL FACILITY.—In the case of a facility using incremental geothermal to produce electricity, the term 'qualified facility' means any facility owned by the taxpayer which is originally placed in service before the date of the enactment of this paragraph, but only to the extent of its incremental geothermal production. In the case of a qualified facility described in the preceding sentence, the 10-year period referred to in subsection (a) shall be treated as beginning not earlier than such date of enactment. Such term shall not include any property described in section 48(a)(3) the basis of which is taken into account by the taxpayer for purposes of determining the energy credit under section 48.

''(10) INCREMENTAL HYDROPOWER FACILITY.—In the case of a facility using incremental hydropower to produce electricity, the term 'qualified facility' means any non-Federal hydroelectric facility owned by the taxpayer which is originally placed in service before the date of the enactment of this paragraph, but only to the extent of its incremental hydropower production. In the case of a qualified facility described in the preceding sentence, the 10-year period referred to in subsection (a) shall be treated as beginning not earlier than such date of enactment.''.

(e) CREDIT ELIGIBILITY FOR LESSEES AND OPERATORS EXTENDED TO ALL FACILITIES.—Paragraph (6) of section 45(d) is amended to read as follows:

''(6) CREDIT ELIGIBILITY FOR LESSEES AND OPERATORS.—In the case of any facility described in paragraph (1), (4), (5), (6), (7), (9), or (10), if the owner of such facility is not the producer of the electricity, the person eligible for the credit allowable under subsection (a) shall be the lessee or the operator of such facility.''.

(f) QUALIFIED FACILITIES WITH CO-PRODUCTION.—Section 45(b) (relating to limitations and adjustments) is amended by adding at the end the following:

''(5) INCREASED CREDIT FOR CO-PRODUCTION FACILITIES.—

''(A) IN GENERAL.—In the case of a qualified facility described in any paragraph of subsection (d) (other than paragraph (8)) which adds a co-production facility after the date of the enactment of this paragraph, the amount in effect under subsection (a)(1) for an eligible taxable year of a taxpayer shall (after adjustment under paragraph (2) and before adjustment under paragraphs (1) and (3)) be increased by .25 cents.

''(B) CO-PRODUCTION FACILITY.—For purposes of subparagraph (A), the term 'co-production facility' means a facility which—

''(i) enables a qualified facility to produce heat, mechanical power, chemicals, liquid fuels, or minerals from qualified energy resources in addition to electricity, and

''(ii) produces such energy on a continuous basis.

''(C) ELIGIBLE TAXABLE YEAR.—For purposes of subparagraph (A), the term 'eligible taxable year' means any taxable year in which the amount of gross receipts attributable to the co-production facility of a qualified facility are at least 10 percent of the amount of gross receipts attributable to electricity produced by such facility.''.

(g) QUALIFIED FACILITIES LOCATED WITHIN QUALIFIED INDIAN LANDS.—Section 45(b) (relating to limitations and adjustments), as amended by subsection (f), is amended by adding at the end the following:

''(6) INCREASED CREDIT FOR QUALIFIED FACILITY LOCATED WITHIN QUALIFIED INDIAN LAND.—In the case of a qualified facility described in any paragraph of subsection (d) (other than paragraphs (1), (2) and (8)) which—

''(A) is located within—

''(i) qualified Indian lands (as defined in section 7871(c)(3)), or

''(ii) lands which are held in trust by a Native Corporation (as defined in section 3(m) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(m)) for Alaska Natives, and

''(B) is operated with the explicit written approval of the Indian tribal government or Native Corporation (as so defined) having jurisdiction over such lands, the amount in effect under subsection (a)(1) for a taxable year shall (after adjustment under paragraphs (2) and (5) and before adjustment under paragraphs (1) and (3)) be increased by .25 cents.''.

(h) ADDITIONAL MODIFICATIONS.—

(1) TREATMENT OF PERSONS NOT ABLE TO USE ENTIRE CREDIT.—Section 45(e) (relating to additional definitions and special rules), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(11) TREATMENT OF PERSONS NOT ABLE TO USE ENTIRE CREDIT.—

''(A) ALLOWANCE OF CREDIT.—

''(i) IN GENERAL.—Except as otherwise provided in this subsection—

''(I) any credit allowable under subsection (a) with respect to a qualified facility owned by a person described in clause (ii) may be transferred or used as provided in this paragraph, and

''(II) the determination as to whether the credit is allowable shall be made without regard to the tax-exempt status of the person.

''(ii) PERSONS DESCRIBED.—A person is described in this clause if the person is—

''(I) an organization described in section 501(c)(12)(C) and exempt from tax under section 501(a),

''(II) an organization described in section 1381(a)(2)(C),

''(III) a public utility (as defined in section 136(c)(2)(B)), which is exempt from income tax under this subtitle,

''(IV) any State or political subdivision thereof, the District of Columbia, any possession of the United States, or any agency or instrumentality of any of the foregoing, or

''(V) any Indian tribal government (within the meaning of section 7871) or any agency or instrumentality thereof.

''(B) TRANSFER OF CREDIT.—

''(i) IN GENERAL.—A person described in subparagraph (A)(ii) may transfer any credit to which subparagraph (A)(i) applies through an assignment to any other person not described in subparagraph (A)(ii). Such transfer may be revoked only with the consent of the Secretary.

''(ii) REGULATIONS.—The Secretary shall prescribe such regulations as necessary to ensure that any credit described in clause (i) is assigned once and not reassigned by such other person.

''(iii) TRANSFER PROCEEDS TREATED AS ARISING FROM ESSENTIAL GOVERNMENT FUNCTION.—Any proceeds derived by a person described in subclause (III), (IV), or (V) of subparagraph (A)(ii) from the transfer of any credit under clause (i) shall be treated as arising from the exercise of an essential government function.

''(C) CREDIT NOT INCOME.—Any transfer under subparagraph (B) of any credit to which subparagraph (A)(i) applies shall not be treated as income for purposes of section 501(c)(12).

''(D) TREATMENT OF UNRELATED PERSONS.—For purposes of subsection (a)(2)(B), sales among and between persons described in subparagraph (A)(ii) shall be treated as sales between unrelated parties.''.

(2) CREDITS NOT REDUCED BY TAX-EXEMPT BONDS OR CERTAIN OTHER SUBSIDIES.—Section 45(b)(3) (relating to credit reduced for grants, tax-exempt bonds, subsidized energy financing, and other credits) is amended—

(A) by striking clause (ii),

(B) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii),

(C) by inserting ''(other than any loan, debt, or other obligation incurred under subchapter I of chapter 31 of title 7 of the Rural Electrification Act of 1936 (7 U.S.C. 901 et seq.), as in effect on the date of the enactment of the Renewable Energy Incentives Act, or proceeds of an issue of State or local government obligations the interest on which is exempt from tax under section 103)'' after ''project'' in clause (ii) (as so redesignated), and

(D) by striking ''**TAX-EXEMPT BONDS,**'' in the heading and inserting ''**CERTAIN**''.

(3) CREDIT ALLOWABLE AGAINST MINIMUM TAX WITHOUT LIMITATION.—Clause (ii) of section 38(c)(4)(B) (defining specified credits) is amended to read as follows:

''(ii) the credit determined under section 45 to the extent that such credit is attributable to electricity or refined coal produced at a facility which is originally placed in service after October 22, 2004.''.

(4) TREATMENT OF QUALIFIED FACILITIES NOT IN COMPLIANCE WITH POLLUTION LAWS.—Section 45(d) (relating to qualified facilities), as amended by subsection (d)(3), is amended by adding at the end the following:

''(11) NONCOMPLIANCE WITH POLLUTION LAWS.—For purposes of this subsection, a facility which is not in compliance with the applicable State and Federal pollution prevention, control, and permit requirements for any period of time shall not be considered to be a qualified facility during such period.''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to electricity and other energy produced and sold after the date of the enactment of this Act, in taxable years ending after such date.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE RESOLUTION 168—EXPRESSING GRATITUDE AND SINCERE RESPECT FOR JESSE R. NICHOLS

Mr. FRIST (for himself, Mr. GRASSLEY, and Mr. BAUCUS) submitted the following resolution; which was considered and agreed to:

S. RES. 168

Whereas Jesse R. Nichols, Sr., faithfully served the United States Senate and the Committee on Finance as the Government Documents Clerk and Librarian from nineteen hundred thirty-seven through nineteen hundred seventy-one;

Whereas Jesse R. Nichols, Sr., was born on June 14, 1909, in Clarksdale, Mississippi, and was the first African American Clerk employed by the United States Senate;

Whereas he carried out his duties in exemplary fashion, bringing credit to the Committee and to Congress;

Whereas Jesse Nichols worked effectively under the guidance of Democratic and Republican Chairmen, including Pat Harrison of Mississippi, Walter F. George of Georgia, Harry Flood Byrd of Virginia, and Russell B. Long of Louisiana from the 75th Congress through the 91st Congress; and

Whereas the Committee on Finance will long remember the commitment, service, and leadership of Jesse R. Nichols, Sr., as documented in an oral history posted on the Senate Historian's website: Now, therefore, be it

Resolved, That the United States Senate expresses its deep gratitude and sincere respect for Jesse R. Nichols for his unfailing service and his dedication to the United States Senate. The Senate hereby expresses condolences to the family due to the death of Jesse R. Nichols, Sr., on February 18, 2005.

SENATE RESOLUTION 169—EXPRESSING THE SENSE OF THE SENATE WITH RESPECT TO FREE TRADE NEGOTIATIONS THAT COULD ADVERSELY IMPACT CONSUMERS OF SUGAR IN THE UNITED STATES AS WELL AS UNITED STATES AGRICULTURE AND THE BROADER ECONOMY OF THE UNITED STATES

Mr. SANTORUM (for himself and Mr. ENSIGN) submitted the following resolution; which was referred to the Committee on Finance:

S. RES. 169

Whereas the President concluded negotiations with Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and the Dominican Republic to form the Dominican Republic-Central America-United States Free Trade Agreement (''CAFTA–DR'');

Whereas the CAFTA–DR only provides the 5 Central American countries and the Dominican Republic with modest additional access to the United States sugar market that will have no impact on United States sugar producers;

Whereas United States farmers and ranchers need access to new markets to expand the agricultural sector of the United States economy;

Whereas the United States manufacturing and service sectors need access to new markets to expand the broader economy of the United States;

Whereas new market access for United States products is only possible through comprehensive free trade agreements that include all products and services;

Whereas the CAFTA–DR will help build democracy, security, and the rule of law, in addition to helping integrate the economies of the United States and countries in the region;

Whereas sugar growers are already one of the most highly protected special interests in the United States;

Whereas the provisions of the CAFTA–DR offer protection to United States sugar growers, in addition to the numerous existing mechanisms that have been designed to shield sugar growers from any competition;

Whereas the United States sugar program has caused the loss of thousands of jobs in the United States in the sugar product manufacturing and cane refining sector;

Whereas every effort has been taken by the administration and Congress to accommodate the United States sugar growers, but they continue to oppose the CAFTA–DR and any free trade agreement containing new market access for sugar; and

Whereas the United States sugar growers' intransigence in wanting to exclude sugar from all future trade agreements threatens to undermine trade opportunities for United States agriculture and the rest of the United States economy: Now, therefore, be it

Resolved, That it is the sense of the Senate that the President should negotiate and sign free trade agreements that are comprehensive in scope in order to ensure that the entire United States economy can benefit from new market opportunities provided by such agreements

SENATE RESOLUTION 170—RELATIVE TO THE DEATH OF J. JAMES EXON, FORMER UNITED STATES SENATOR FOR THE STATE OF NEBRASKA

Mr. FRIST (for himself, Mr. REID, Mr. HAGEL, Mr. NELSON of Nebraska, Mr. AKAKA, Mr. ALEXANDER, Mr. ALLARD, Mr. ALLEN, Mr. BAUCUS, Mr. BAYH, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BROWNBACK, Mr. BUNNING, Mr. BURNS, Mr. BURR, Mr. BYRD, Ms. CANTWELL, Mr. CARPER, Mr. CHAFEE, Mr. CHAMBLISS, Mrs. CLINTON, Mr. COBURN, Mr. COCHRAN, Mr. COLEMAN, Ms. COLLINS, Mr. CONRAD, Mr. CORNYN, Mr. CORZINE, Mr. CRAIG, Mr. CRAPO, Mr. DAYTON, Mr. DEMINT, Mr. DEWINE, Mr. DODD, Mrs. DOLE, Mr. DOMENICI, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. ISAKSON, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LOTT, Mr. LUGAR, Mr. MARTINEZ, Mr. MCCAIN, Mr. MCCONNELL, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Florida, Mr. OBAMA, Mr. PRYOR, Mr. REED, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SALAZAR, Mr. SANTORUM, Mr. SARBANES, Mr. SCHUMER, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. STEVENS, Mr. SUNUNU, Mr. TALENT, Mr. THOMAS,