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House of Representatives

The House was not in session today. Its next meeting will be held on Monday, December 7, 2009, at 10.30 a.m.

Senate

FRIDAY, DECEMBER 4, 2009

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

PRAYER

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

Let us pray.

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

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

PLEDGE OF ALLEGIANCE

The Honorable MARK R. WARNER led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 4, 2009.

To the Senate:

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

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

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

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

HEALTH CARE REFORM

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

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

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

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

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

Unfortunately, Senate Republicans are less interested in solving problems than they are in creating them. The day before this floor debate began, the assistant Republican leader—the junior Senator from Arizona—said: ''There is no way to fix this bill.'' Of course, that is absolutely totally wrong.

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

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

Our goal remains the same as it was last November when the American people called in a loud and clear voice for change. It remains the same as it did 31 years ago, when Senator Ted Kennedy called it shameful that ''in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.''

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

Each moment in this fight is historic. No bill to put health care decisions in the hands of the people has ever come this far. But the most historic days of the journey lie ahead. We can only seize that opportunity if this debate is about facts, not about fear.

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

This is not the first time I have asked my Republican friends to think of the real families across this Nation who face real problems—families with real diseases, real sicknesses, real medical bills, and real fears. It is not the first time I have warned that America has no place for those who hope for failure.

This is not the first time I have extended my hand across the aisle and asked my Republican friends to abandon their shortsighted strategy to bring the Senate to a screeching halt; for example, issuing an informational guide on how to stop and slow things. That doesn't work. We need a strategy that says we can win because that will mean the American people do not lose.

So I hope that, for the first time, we will have people of good will on the Republican side of this Chamber who will walk over and say: Let's work together to get some things done. I have had a couple good conversations the last few days with some of my colleagues on the other side of the aisle. I hope we can move forward. This is a bill that doesn't look at a person who is sick or hurt or afraid as being a Democrat or a Republican or an Independent. They are Americans. They are from Virginia, Montana, Nevada and from all over America and they are people who are calling upon us to do the right thing.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, we had a very clarifying vote on the Senate floor about the direction of our friends on the other side with regard to our health care system. Yesterday, all but two of them voted to preserve nearly $½ trillion in cuts to Medicare, the health program for our seniors. In the runup to that vote, they said these cuts were not cuts and that Medicare Advantage in particular is not a part of Medicare, arguments plainly contradicted by the text of the bill itself, by the Department of Health and Human Services, by the independent Congressional Budget Office, and by the experience of seniors themselves.

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

Yesterday's vote was particularly distressing for the nearly 11 million seniors on Medicare Advantage. So today Members will have an opportunity to undo the damage they voted to do to this program. With yesterday's vote, proponents of this measure authorized $120 billion in cuts to Medicare Advantage and in the process they expressly voted to violate the President's pledge that seniors who like the plans they have can keep them. The President has said seniors who like the plans they have can keep them—because you can't cut $120 billion from a benefits program, obviously, without cutting benefits.

The Congressional Budget Office has been crystal clear on this matter. When asked about the effect these cuts would have on Medicare Advantage, the Director of CBO was unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill.

This is the Director of the Congressional Budget Office being unequivocal. He said that approximately half of Medicare Advantage benefits will be cut for nearly 11 million seniors enrolled in this program under this bill. That is what our friends on the other side voted for yesterday and they know it.

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

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

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

I yield the floor.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

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

Pending:

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

Whitehouse amendment No. 2870 (to amendment No. 2786), to promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this act.

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

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, we are beginning our fifth day of consideration on the health reform bill. We will be in a period of debate only until about 11:30 a.m. Pending now is the

amendment by the Senator from Rhode Island, Mr. WHITEHOUSE, on fiscal responsibility. Also pending is a motion to commit by the Senator from Utah on Medicare Advantage. It would be my hope that the Senate will vote on these matters today.

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

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

The assistant legislative clerk proceeded to call the roll.

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

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

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

The Senator from Montana is recognized.

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

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

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

But it is not simply the Federal budget on the line, it is the family budget too. Incredibly, in total we are spending 80 times as much on health care today as we did five decades ago—80 times more on health care today than we did five decades ago. Now family budgets are breaking under the strain—already. That is going to get worse if we do nothing. The cost of the average family health care plan will reach $24,000 in the year 2016. That is not too many years away from now. This represents an 84-percent increase over 2008 premium levels. That means, if we do nothing, in fewer than 10 years most families would have to dedicate half of their household budget to health insurance. For years we have heard the warnings from Federal budget experts. Now we are hearing every day from folks back home who simply cannot afford the care they need.

We have an obligation to act. Now we have an opportunity to act. The country's leading economists and Federal budget experts laid out strategies and options for getting costs under control. We have taken their recommendations to heart. There is a lot of agreement among those who study these issues of what we must do. Now we have a bill that does what they suggest. It also passes the test of fiscal responsibility.

We have many reasons to vote for this bill. It protects and even increases Medicare benefits for seniors. It achieves near universal coverage in less than 10 years. That means it achieves the goal of virtually everybody having health insurance in that period of time. It slows the growth of Federal health care spending. It stops insurance industry discrimination and, based on independent, nonpartisan analysis, makes a serious dent in our Federal deficit.

This chart behind me represents what 2 weeks ago the Congressional Budget Office and Joint Committee on Taxation confirmed in no uncertain terms, that deficits go down under this plan. The official cost estimate reads as follows:

> The Congressional Budget Office and the Joint Committee on Tax estimates that on balance the direct spending and revenue effects of enacting this Patient Protection and Affordable Care Act legislation would yield a net reduction in Federal deficits of $130 billion over the years 2010 to 2019. That is represented by the green bar on the left. It is a net $130 billion reduction during the first 10 years of this bill.

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

According to the CBO, this bill also slows the growth of Medicare costs, which has been a principal goal in our Medicare debate since day one. Medicare spending would grow 6 percent annually instead of 8 percent annually. In other words, Medicare would continue to grow but, unlike today, it will grow at a sustainable rate.

Of course, no projections, even from the Congressional Budget Office, can be certain. We can safely say this bill will put us on the right track. We can safely say this bill is better than doing nothing. No honest assessment challenges the case for acting now to slow the growth of Federal spending. No honest assessment challenges the case. And no honest assessment of this bill challenges the CBO analysis. I have not heard one. I have not heard an honest challenge to the CBO analysis, nor have I heard of a good, honest case for not acting now to slow the growth of Federal spending, which means we have many reasons to pass health care reform, not the least of which is the long-term financial health of the economy and our Nation. But the reasons for passing this are much more than simply facts and figures. This is about Americans from every corner of this great country, struggling to make ends meet, forced into bankruptcy by medical tragedy. This is about stopping insurance industry discrimination; this is about saving Medicare for our seniors and reducing the deficit for our grandchildren.

I don't know which other Senators wish to speak. Senator BINGAMAN wishes to gain recognition in the time we have.

Let me ascertain how much time we have and how many speakers we have.

The ACTING PRESIDENT pro tempore. The Senator has 40 minutes.

Mr. BAUCUS. I yield 15 minutes to the Senator from New Mexico.

The ACTING PRESIDENT pro tempore. The Senator from New Mexico.

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

I want to spend a few minutes talking about health care reform both as it affects the country but also as it affects my home State of New Mexico. First, I would like to discuss the context for this health reform bill, and that is the very serious problem we face in the country with the growing cost of health care, if the Congress fails to act. We have a chart I will put up, since everyone has charts. This is a chart that shows what is happening to all health care costs and has been happening since 1960. We can see that as a percent of the gross domestic product, back in 1960 we were spending right at 5 percent of GDP on all health care. Today we are spending much more like 16 percent of the gross domestic product on health care. The projections for the future, if we do not act to reform the health care system, are very serious indeed.

Let me allude to an article in the morning New York Times. This is by Nobel award-winning economist Paul Krugman of Princeton University. He talks about this issue of fiscal responsibility and the impact of health care reform on the deficit. It talks about how some Senators have concerns about going ahead with this health care reform bill because of what it might cost. He makes the point:

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

I ask unanimous consent that the full column from the New York Times

of this morning be printed in the RECORD following my remarks.

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

(See exhibit 1.)

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

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

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

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

Nowhere is the unsustainable growth felt more acutely than in my home State. Without health reform, in my State we are projected to experience the greatest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico was about $6,000 in the year 2000. By 2006, this rate had almost doubled, or the cost had almost doubled to $11,000. By 2016, the amount is expected to rise to an astonishing $28,000. In addition, health insurance premiums in New Mexico make up a larger percentage of New Mexico's income, the income of the average New Mexico family, than almost all other States. We are paying 31.18 percent. Over 31 percent of the average income of a family in New Mexico is going to pay for health care. This is expected to grow to 56 percent if we do not reform our health care system.

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

Data from the McKinsey Global Institute clearly indicates there is a considerable level of waste in our current system. McKinsey estimates that the United States spends nearly $½ trillion annually in excess of other similarly situated nations. Of this, about $224 billion in excess costs are found in hospital care. About $178 billion are found in outpatient care. Together these account for more than 80 percent of U.S. spending above the levels of other nations.

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

We have a very serious problem that needs addressing. It is clear that the U.S. health care system is failing many Americans. The situation is becoming more and more urgent. According to a study published by the Harvard Medical School in August, medical costs have led to almost two-thirds of the bankruptcies in this country. More than 26 percent of bankruptcies are attributable to health care problems. The study found that most medical debtors were well educated, owned their own homes, had middle-class occupations and, shockingly, three quarters had health insurance. So these were people who had coverage, but the coverage was not adequate to meet the needs. Unfortunately, for many individuals, the very high cost of medical care leads them to delay or to avoid receiving medical care altogether.

The Urban Institute reports that 137,000 people in this country died between 2000 and 2006 because they lacked health insurance. That includes 22,000 people in 2006. Clearly, the need for national health reform has never been so great.

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

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

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

Finally, these new health insurance exchanges will help improve choices by allowing families and businesses to compare insurance plans on the basis of price and performance. This puts families, rather than the insurance companies or the government bureaucrats, in charge of health care. It helps people to decide which quality, affordable insurance option is right for them.

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

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

Let me also point out the contrast. We are talking about a bill which the

Congressional Budget Office says will reduce the size of the deficit in future decades. I can remember a couple Congresses ago when we had a debate on adding subpart D to Medicare, Part D to Medicare. There are many on the floor who are concerned about cost today—at least they say so in their speeches—who were very anxious to add that legislation to Medicare, adding another $500 billion. That was estimated by the CBO at that time: another $500 billion over a 10-year period to the cost that Medicare was bearing.

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

On the subject of premium cost, CBO has also found that in the individual market, the amount that subsidized enrollees would pay for non coverage would be roughly 56 percent to 59 percent lower, on average, than the premiums charged in the individual market under current law. Among enrollees in the individual market who would not receive new subsidies, average premiums would increase by less than 10 to 13 percent. The legislation would have smaller effects on premiums for employment-based coverage. Its greatest impact would be on smaller employers qualifying for new health insurance tax credits. For these businesses and their employees, CBO predicts premiums would decrease by about 8 percent to 11 percent compared with their costs under current law.

This is consistent with estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent. In addition, about two-thirds of New Mexicans could potentially qualify for subsidies or Medicaid and nearly a quarter would qualify for near full subsidies or Medicaid.

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

Finally, much of the debate on health care reform has focused on insurance coverage but it is important to recognize that as we expand coverage to include more Americans, the demand for health care services will also increase. A strong health care workforce is therefore essential for successful health reform. Within the United States, approximately 25 percent of counties are designated health professions shortage areas—a measure indicating that there is insufficient medical staff to properly serve that geographic area. The problem is even more apparent in rural States such as New Mexico. For example, 32 out of 33 counties in my State has this shortage designation. As a result, New Mexico ranks last compared to all other states with regard to both access to health care and utilization of preventative medicine.

The Patient Protection and Affordable Care Act we are debating contains key provisions to improve access and delivery of health care services throughout the Nation. These provisions include increasing the supply of physicians, nurses, and other health care providers; enhancing workforce education and training; and providing support to the existing workforce.

I applaud Senators REID, BAUCUS, DODD, HARKIN, and many other colleagues who have worked so hard on this bill. This legislation represents true healthcare reform. It is time for the Senate to put partisanship aside and enact this critical and long overdue legislation.

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

EXHIBIT 1

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

REFORM OR ELSE

(By Paul Krugman)

Health care reform hangs in the balance. Its fate rests with a handful of ''centrist'' senators—senators who claim to be mainly worried about whether the proposed legislation is fiscally responsible.

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

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

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

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

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

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

Are we talking about real savings, or just window dressing? Well, the health care economists I respect are seriously impressed by the cost-control measures in the Senate bill, which include efforts to improve incentives for cost-effective care, the use of medical research to guide doctors toward treatments that actually work, and more. This is ''the best effort anyone has made,'' says Jonathan Gruber of the Massachusetts Institute of Technology. A letter signed by 23 prominent health care experts—including Mark McClellan, who headed Medicare under the Bush administration—declares that the bill's cost-control measures ''will reduce long-term deficits.''

The fact that we're seeing the first really serious attempt to control health care costs as part of a bill that tries to cover the uninsured seems to confirm what would-be reformers have been saying for years: The path to cost control runs through universality. We can only tackle out-of-control costs as part of a deal that also provides Americans with the security of guaranteed health care.

That observation in itself should make anyone concerned with fiscal responsibility support this reform. Over the next decade, the Congressional Budget Office has concluded, the proposed legislation would reduce, not increase, the budget deficit. And by giving us a chance, finally, to rein in the ever-growing spending of Medicare, it would greatly improve our long-run fiscal prospects.

But there's another reason failure to pass reform would be devastating—namely, the nature of the opposition.

The Republican campaign against health care reform has rested in part on the traditional arguments, arguments that go back to the days when Ronald Reagan was trying to scare Americans into opposing Medicare—denunciations of ''socialized medicine,'' claims that universal health coverage is the road to tyranny, etc.

But in the closing rounds of the health care fight, the G.O.P. has focused more and more on an effort to demonize cost-control efforts. The Senate bill would impose ''draconian cuts'' on Medicare, says Senator John McCain, who proposed much deeper cuts just last year as part of his presidential campaign. ''If you're a senior and you're on Medicare, you better be afraid of this bill,'' says Senator Tom Coburn.

If these tactics work, and health reform fails, think of the message this would convey: It would signal that any effort to deal with the biggest budget problem we face will be successfully played by political opponents as an attack on older Americans. It would be a long time before anyone was willing to take on the challenge again; remember that after the failure of the Clinton effort, it was 16 years before the next try at health reform.

That's why anyone who is truly concerned about fiscal policy should be anxious to see health reform succeed. If it fails, the demagogues will have soon, and we probably won't deal with our biggest fiscal problem until we're forced into action by a nasty debt crisis.

So to the centrists still sitting on the fence over health reform: If you care about fiscal responsibility, you better be afraid of what will happen if reform fails.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, how much time remains under the control of the majority?

The ACTING PRESIDENT pro tempore. Twenty-four minutes.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Massachusetts.

Mr. KIRK. Mr. President, I thank the Senator.

Mr. BAUCUS. We might be able to find extra time, too, if the Senator is looking for extra time. Right now, according to the number of Senators who

want to speak, that is all we have in this first block. But sometimes we can work things out—if the Senator wants to talk a little longer. But right now it is 10 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KIRK. Mr. President, I thank Senator BAUCUS.

AMENDMENT NO. 2870

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

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

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

Senator Kennedy also understood it is morally wrong when that infirm or elderly individual's friends or loved ones must also face heartbreaking choices: Do I give up my job and commit my time to care for my infirm parent at the expense of my own family and children or do I resign myself to confining my aging mother or father to a facility?

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

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

Under the CLASS Act, a worker in Massachusetts, or any other State, can choose to pay a premium into this voluntary insurance program through affordable payroll deductions. After contributing for 5 years, they become eligible for a cash benefit of at least $50 a day if they become disabled. That cash benefit can make the difference in allowing a disabled person to live with independence, self-respect, and dignity.

For example, it can pay for having a ramp installed to their home or to pay for needed transportation or to purchase a computer to work from home and remain self-sufficient. It can also pay for a caregiver to come to their home, help them bathe, get dressed, and cook meals—services that otherwise often fall to family and friends who are forced to work reduced hours on their own jobs or quit those jobs altogether to provide that needed care.

Currently, long-term care, as we know it, is paid for through a fragmented combination of sources, including family budgets, Medicaid, Medicare, and private insurance. Without a prior and voluntary insurance investment, which the CLASS Act offers, paying for long-term care can be financially catastrophic for many individuals and families, since home care and nursing homes can cost over $70,000 a year.

Only one in five individuals can afford private long-term care insurance, and many are excluded because of preexisting conditions. Medicare's role in providing long-term services is extremely limited, covering only short-term skilled nursing care and home health. This lack of options forces many people to turn to Medicaid, which is our Nation's primary payer and only safety net program providing comprehensive long-term care services and supports.

But who is eligible for Medicaid? People only qualify for Medicaid if they are or become poor. This criterion forces many families to impoverish themselves to obtain the Medicaid support they need. We have all heard the stories: The family member works hard all his or her life, and then due to an accident they cannot afford to pay for needed services and supports out of their pocket. So they now must give up their savings to become eligible to turn to the government and to Medicaid to provide the proper care they need to survive. No one wins—not the disabled or elderly parent, not the family caregiver, not the government, and not Medicaid.

I have a letter from a woman who lives on Cape Cod in Massachusetts. She knows firsthand how powerful the CLASS Act could be for families. Jerilyn has been caring for her sister who is brain damaged, legally blind, paralyzed, and incontinent. Jerilyn writes:

Caring for my sister at home has saved the state thousands and thousands of dollars every year and we have done this care for 38 years. We fight every year to get sufficient hours for PCA care with Mass Health. We are holding down full time jobs which also supplement my sister's care. This is so wrong. Instead of encouraging families who want to keep their loved ones at home and save the state money, they work against us so I believe we will give up and just place them in nursing homes . . . which in turn cost the state more money . . . is this not totally crazy?

She is asking the right question. The CLASS Act will help turn this serious, no-win situation into an everyone-wins result. It gives individuals with disabilities and their families the funds they need to obtain some of the services they need without having to resort to Medicaid.

The current reliance on Medicaid is not only a strain on our families, it is also a strain on our already overburdened Medicaid system. Today, Medicaid spends nearly $50 billion a year on long-term services and supports. Estimates indicate that by 2045 that spending could exceed $200 billion. Obviously, this current course is unsustainable.

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

Make no mistake, as it stands today, if someone without adequate long-term care coverage becomes disabled, they will more than likely have to turn to the already overburdened Medicaid system to get the help they need. The CLASS Act is designed to specifically remedy this looming crisis by giving people an affordable option other than Medicaid. The act will save the system over $1.6 billion over the first 4 years that people start receiving benefits.

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

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

Let me repeat that final point, since I have often heard it misrepresented.

No taxpayer funds will be used to pay benefits. Benefits will be paid through self-funded and voluntary premiums.

During the markup in the HELP Committee this summer, Senator DODD led a main discussion about this program. With the help of the Republicans on the committee, especially Senator GREGG of New Hampshire, additional safeguards were included to ensure that the act will stand on strong financial footing for years to come. After the committee adopted Senator GREGG's 75-year solvency amendment, the program won strong words of support from both parties. We credit Senator GREGG for that constructive contribution.

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

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 8 minutes to the Senator from Wisconsin, the chairman of the Special Committee on Aging.

The ACTING PRESIDENT pro tempore. The Senator from Wisconsin.

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

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

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

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

In terms of the cuts to Medicare Advantage, this bill will only cut back on overpayments to these private Medicare plans. Benefits will not be affected. AARP also supports these cuts because they understand that most of the overpayments are going to insurance company profits, not to seniors' benefits, and that this overspending is putting Medicare on a faster path to insolvency. Experts say by making these cuts, health reform will extend the solvency of the Medicare trust fund by 5 years, without making one cut to guaranteed benefits.

I understand people complain that this bill is too long. But any bill that seeks to offer choice and meet the needs of so many Americans is, by necessity, complex. We cannot gloss over these vital issues. So I would like to take a minute to share with you some of the provisions that have not received as much attention but are, nevertheless, crucial to improving America's health care system. There is a lot in this bill for older Americans, retirees, and those planning ahead for a healthy and happy long life. The Aging Committee has worked closely with the leadership of the HELP and Finance Committees to improve several of our provisions, most of which have bipartisan support. I wish to particularly thank Senator BAUCUS, Senator DODD, Senator HARKIN, and Majority Leader REID for being so willing to work with us on these important issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The ACTING PRESIDENT pro tempore. Five minutes.

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

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

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

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

Mr. WYDEN. Mr. President, I wish to spend a few minutes this morning talking about Medicare Advantage and particularly to highlight the fact that I

think it is important to support the language put together by the chairman of the Finance Committee on Medicare Advantage and to reject the amendment offered by our friend from Utah, Senator HATCH.

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

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

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

In addition, in the Finance Committee I offered an amendment with several colleagues that would boost the payments to those plans that, according to the government—and the government uses a system of stars, in effect, to reward quality—our amendment would boost the payments to those Medicare Advantage plans with four- and five-star quality ratings.

So, in effect, with our legislation there are both carrots and sticks. Competitive bidding plus bonus payments offers both, so the plans compete to provide the best value for seniors. By encouraging the plans to be more efficient, it is possible to achieve significant savings for older people, help shore up the solvency of the Medicare trust fund, and meet the cost-saving goals of the legislation.

One point that has been discussed by colleagues on the floor of the Senate is this matter of individuals being able to keep what they have. I have heard that is not the case with Medicare Advantage plans; that somehow, under the legislation that has been offered by the Finance Committee, older people would not be able to keep what they have, according to some on the floor. That is simply inaccurate. Seniors who have Medicare Advantage plans under the Baucus legislation will be able to keep those plans. They will be able to stay with what they have, keep their guaranteed, essential benefits, and through the language that has been authored now in the legislation before us, there will be lower costs for taxpayers.

Last point. I have heard a lot of talk about grandma on the floor of the Senate. I spent the bulk of my professional life in effect working with grandma. I was the cofounder of the Oregon Gray Panthers and ran the legal aid program for older people in our home State for a number of years. I want it understood that I think with the Baucus legislation on Medicare Advantage, that proves it is possible to make savings in the Medicare Program without cutting essential benefits. Using commonsense principles of competitive bidding, No. 1, and incentives for quality, I think grandma is going to be just fine under our language for Medicare Advantage.

Mr. President, with that, I yield the floor.

Mr. BAUCUS. Mr. President, how much time is remaining on the majority side?

The ACTING PRESIDENT pro tempore. Three minutes.

Mr. BAUCUS. And on the minority side?

The ACTING PRESIDENT pro tempore. Fifty-five minutes.

Mr. BAUCUS. Mr. President, I reserve the remainder of the majority time.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, during the next 55 minutes, we will have several Republican Senators come to the floor. I ask unanimous consent that during that time, Senator MCCAIN be allowed to be the manager of a colloquy among the Republican Senators.

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

Mr. ALEXANDER. Mr. President, before Senator MCCAIN begins, if I may, I wish to take a moment to establish where we are today and what happened yesterday as a lead-in to what he is about to discuss.

Yesterday, Senator MCCAIN offered an amendment on the floor of the Senate that would do two things: It would send this 2,074-page Democratic health care bill back to the Finance Committee and say to them, No. 1, take out the cuts in Medicare, and No. 2, any savings in Medicare must go to make Medicare more solvent. That is what the McCain amendment would have accomplished. That was defeated. Fifty-eight Democrats said yes to the cuts in Medicare. They said yes to using the money that comes from these cuts to create a new entitlement program. Forty Republicans and two Democrats said, no, we don't want cuts to Medicare and we do not want a new entitlement program.

So yesterday we made it clear that the central core of this bill includes nearly $½ trillion in cuts to Medicare. There is no question about that. Everyone concedes that. The President said that when he addressed us. The Congressional Budget Office says that. The question is whether it is a good idea or a bad idea, and yesterday, by 58 votes, the Democrats said yes to these cuts in Medicare.

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

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

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

Why do they choose it? Well, it includes some benefits they may not have in the original Medicare plan. These benefits include dental care, vision care, hearing coverage, reduced hospital deductibles, lower co-payments, lower premiums, coordinated

chronic care management, and physical fitness programs.

The distinguished Senator from Oregon was on the floor and he mentioned grandma. I have mentioned grandma a few times—no disrespect to grandpa; he is in the same boat. He said grandma didn't need to worry about her Medicare Advantage plan because none of the benefits would be cut. That is not what the Director of the CBO, who is often cited by the chairman of the Finance Committee, has said. He said that half of the benefits currently provided to seniors under Medicare Advantage would disappear under the Finance Committee plan, which is much like the plan we are considering. The benefits that would disappear would include those I mentioned.

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

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

But amnesia is not confined to one side of the aisle around here. I ask my friend from Tennessee—you know this discussion about Medicare Advantage—we have to better understand what is this program and why is it so popular. Is it because it offers seniors a chance to get additional benefits? Maybe the Senator can give a short definition of that. I think the American people may not be totally clear on what we are discussing here and why 11 million Americans—over 300,000 citizens in my own State—have chosen Medicare Advantage, and that has prompted, according to Bloomberg, Senator CASEY of Pennsylvania, to say, ''We are not going to be able to say 'if you like what you have, you can keep it.''' ''That basic commitment that a lot of us around here have made will be called into question.''

The title of that is ''Dem Senator Says Medicare Advantage Cuts Break President's Pledge.''

Maybe the Senator from Tennessee can give me a brief outline of what seniors get under Medicare Advantage and why it is so popular with 330,000 senior citizens in my State and 11 million in the country.

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

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

Mr. MCCAIN. Lower income seniors.

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

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

Let me get this straight. Again, the American people should understand this. We voted to cut drastically a program that seniors have taken advantage of, which gives them additional hearing, vision, dental, and physical fitness care, while we practice it here every single day. Every day, there is a physician on duty—more than one—not very far from where I speak, who is ready to give us instant care. If hospitalization is needed, we can get instant transportation to the Bethesda Naval Hospital, where we will get free care. Incredibly, the Senate, on largely partisan lines, yesterday voted against senior citizens in this country, most of whom have paid a lot more into the program than we have. We are going to deprive them of what we have every single day we are members of the Senate.

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

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

For your information, AARP has received $18 million in stimulus money. There is a job creator for you. AARP, which has given its full-throated support to the Democratic health care legislation, even though seniors remain largely opposed, received an $18 million grant in the economic stimulus package for a job training program that has not created any jobs, according to the Obama administration's recovery.gov Web site. That is astonishing to me because from everything I have ever seen, they have created millions of jobs, including in the ninth congressional district of Arizona, where they said they created thousands of jobs. Unfortunately, we only have eight congressional districts, but that is OK.

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

So, my friends, also I might add that in 2006, AARP received $18 million from the Federal Government, and we are reserving additional Federal moneys that they get.

The most important thing is this, and let's make it clear: AARP will receive direct benefits because seniors

who have cuts in their Medicare Advantage and other Medicare programs can buy—guess what—a Medigap insurance policy from AARP—in other words, to cover the things being cut back under this legislation, and it costs $175 a month. The Medicare Advantage premiums are zero for most seniors or $35 a month. Again, if the Medicare Advantage plans go away, people would have to buy a Medigap plan sold by—you got it—AARP. And some low-income seniors could not afford $175 a month.

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

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

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

Mr. MCCAIN. Yes.

Mr. KYL. The Senator was making the point that you cannot take $120 billion out of the program without hurting folks. Those on the other side of the aisle said we can do that—we can cut it by $120 billion and it still won't hurt anybody. My colleague asked the Senator from Tennessee exactly what some of the benefits were and he repeated them. I went to get the actual statistical number of how much it will actually reduce benefits in terms of actuarial value. According to the Congressional Budget Office, in the year 2019, when fully implemented, here is the statistic: The actuarial value of the reduction in benefits under Medicare Advantage is 64 percent; in dollar terms, it goes from $135 a month down to $49 a month. In other words, the very things my colleague talks about—vision care, dental, all of those things——

Mr. MCCAIN. All of the things we routinely use in the Senate. I hope those who voted to harm the seniors in this country and not allow them to have dental, vision, and other health care would unilaterally disavow the use of the physician care and vision care and hearing care available to all of us 24 hours a day right here in the Senate.

Mr. KYL. The last point. I want to say that I hear my colleague loudly and clearly. I hope the American people do too because you cannot call a $120 billion cut something that doesn't hurt people, and especially when the Congressional Budget Office itself says, yes, that reduces these very benefits from a value of $135 a month down to $49 a month. That is a huge cut in the value of the services they receive under Medicare Advantage. That is what we are trying to prevent by this amendment.

Mr. MCCAIN. Could I mention one other thing? I will not spend that much more time on AARP. But the reason I do is because every time the Senator from Montana stands up, he talks about AARP endorsing this rip-off of the American people.

Let me quote again from a Bloomberg article entitled ''AARP's Stealth Fees Often Sting Seniors With Costlier Insurance.'' I quote from the Bloomberg article just briefly:

> Arthur Laupus joined AARP because he thought the nonprofit senior-citizen-advocacy group would make his retirement years easier. He signed up for an auto insurance policy endorsed by AARP, believing the advertising that said he would save money.
>
> He didn't. When Laupus, 71, compared his car insurance rate with a dozen other companies, he found he was paying twice the average. Why? One reason, he learned, was because AARP was taking a cut out of his premium before sending the money to Hartford Financial Services Group, the provider of the coverage. . . .
>
> AARP uses the royalties and fees to fund about half the expenses that pay for activities such as publishing brochures about health care and consumer fraud—as well as for paying down the $200 million bond debt that funded the association's marble and brassstudded Washington headquarters.
>
> In addition, AARP holds clients' insurance premiums for as long as a month and invests the money, which added $40.4 million to its revenue in 2007. . . .
>
> During the past decade, royalties and fees have made up an increasing percentage of AARP's income, rising to 43 percent of its $1.17 billion in revenue in 2007 from 11 percent in 1999, according to AARP data.

This is a Bloomberg article. This is not from the Republican Policy Committee.

The point is, who gains? Who gains from this legislation? Who is going to make hundreds of millions of dollars more because they provide the Medigap policies people will be deprived of when we kill off Medicare Advantage? AARP.

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

The only thing I would emphasize is what the Senator from Arizona has said is that disproportionately low-income Americans in Texas, Idaho, Tennessee, Wyoming, and Utah are hurt. Only one-third of eligible White seniors who do not have Medicaid or employer-based insurance are enrolled in Medicare Advantage. But the number increases to 40 percent for African Americans and 53 percent for Hispanics.

Mr. MCCAIN. May I ask the Senator again, he described the benefits that are provided under the Medicare Advantage program that seniors can have if they want, right? Are those same benefits—dental, vision, hearing, and fitness care—available under regular Medicare today?

Mr. ALEXANDER. My understanding is the answer is no. That it is the reason 11 million Americans choose Medicare Advantage because these benefits are not available under the original Medicare plan.

Mr. MCCAIN. In Montana, there are 27,000 enrollees who will see a 24-percent decrease. In Connecticut, there are 94,000 enrollees who will see a 14-percent decrease. By the way, some special deals have been cut for three States I understand—Oregon, New York, and Florida. We are going to try to fix that. There is no reason one State should be shielded any more than another from these draconian measures. We are going to try to fix that situation.

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

Mr. ALEXANDER. I might say we are operating under a colloquy managed by Senator MCCAIN. So Republican Senators are free to engage in discussion.

Mrs. HUTCHISON. Mr. President, I very much appreciate what the Senators have been talking about because what Senator MCCAIN is saying is that these seniors who are low income have an affordable option, and it is less expensive than the AARP option that would give them this extra care—the eye care, the dental care, the hearing aids. It is an affordable extra option.

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

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

Mr. CRAPO. That is absolutely the case. I would like to point out, when we had the Finance Committee markup, I asked CBO Director Elmendorf directly whether provisions in the bill,

which are still in the bill, would reduce the benefits that Medicare recipients received. His response was:

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

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

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

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

Mr. HATCH. I would be delighted to. To be clear, so-called overpayments to Medicare Advantage plans do not go to the plans. As a matter of fact, they go to the seniors in the form of extra benefits. That is a pretty important point a lot of people miss. Seventy-five percent of the additional payments to Medicare Advantage plans are used to provide seniors with extra benefits, including chronic care management—you would think you would want to do that—hearing aids, eyeglasses. The other 25 percent of any extra payments are returned to the Federal Government. I cannot imagine why anybody would not want to do that.

Mrs. HUTCHISON. Mr. President, I ask the distinguished Senator from Utah to also respond to the arguments that claim that the government cannot afford now to continue overpaying these private plans and that the Medicare trust fund is going broke. Of course, we tried actually several years ago to shore up the Medicare Program, trying to do it in a responsible way, not cutting out the Medicare benefits these seniors can receive as an affordable option. What does the Senator say to that?

Mr. HATCH. The Senator from Texas pointed out the Medicare trust fund is going broke. Yet what do we have on the other side? They take almost $500 billion out of Medicare. Trust me, I am deeply concerned about the solvency of the Medicare trust fund.

Mr. MCCAIN. May I say it is my understanding that Dr. BARRASSO has actually seen Medicare Advantage patients. He and Dr. COBURN are probably the only two. Maybe we could let him give us the benefit of his experience and also not only the benefit of his experience, but I am sure he is going to tell us what the impact is going to be on the low-income seniors from his State.

Mr. BARRASSO. I agree with the Senator from Arizona that people choose to be on Medicare Advantage. Mr. President, 11 million people have chosen to be on Medicare Advantage because it is a wise choice to make because they get better benefits. They get dental care, they get the vision care, they get the hearing aids, they get the fitness thing.

Mr. MCCAIN. Just as we do.

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

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

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

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

Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medicare cuts at the heart of health care legislation. . . .

It goes on to say:

Approval would have stripped out money to pay for expanding coverage to tens of millions of uninsured Americans.

So they are going to take $460 billion, it says, away from our seniors who depend on it for their Medicare and start a whole new government program. The Washington Times, front-page story headline, reads: ''Democrats Win $400B in Medicare Cuts. McCain Pushed for Another Way to Pay for It.''

I look at this and say this is not fair to our seniors, not fair to the patients I have taken care of for 25 years in Wyoming, taken care of folks—taken care of folks—when grandmom breaks her hip, what we need to do for our patients. These are choices people have made.

Mr. President, 11 million Americans have chosen Medicare Advantage because there is an advantage to them for the health care they get—the additional services, the coordinated care, the preventive care. Anyone who looks at this and studies it says: I want to sign up.

It has been wonderful in rural areas and big cities. This has helped a lot of people in the country. It is not surprising that one out of four people in the country on Medicare have chosen Medicare Advantage, but yet what we are seeing here is Democrats want to get rid of Medicare Advantage.

Mr. MCCAIN. Let me get this straight. Basically, by removing the choices that seniors have as a part of Medicare Advantage—dental, vision, hearing, fitness—we are taking away from them what we ourselves enjoy every single day in the Senate?

Mr. BARRASSO. We are taking it away from seniors and using all that money to start a new government program when we know Medicare is going to go broke by 2017.

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

In the end, I believe we not only actually help seniors be more healthy but save a lot of money in the end. Trust me, I am deeply concerned about the solvency of the Medicare trust fund. We have been sounding that alarm for years. That is why it is so shocking we are debating a $2.5 trillion health reform bill that does almost nothing to make sure Medicare is sound and, in fact, does a lot of things to make it unsound, or almost nothing to make sure Medicare is around for future generations.

Instead, we are just creating another Federal entitlement program that we cannot afford while Medicare has $38 trillion in unfunded liabilities.

Mr. CRAPO. The Senator is absolutely right. A lot of people trying to defend these cuts are saying these extra costs in the Medicare Advantage Programs are just going to make insurance companies' profits bigger and help pay for large CEO salaries. Nothing could be further from the truth. The reality is, as the Senator from Utah already indicated, 75 percent of this 14 percent extra payment in these plans go to provide the seniors with the extra benefits we are talking about, and then 25 percent is returned to the Federal Government, not to insurance companies, not to CEOs.

I have a chart. We are going to make it into a bigger one. But those who support this program say we are not cutting Medicare benefits. This chart—I apologize it is a little bit small—but this is a chart of the United States. It shows what is happening to the benefits of Medicare Advantage beneficiaries. As you might guess, the dark red is more than 50 percent reduction in the benefits of the people in those dark red States. In the medium red color, it is between a 25- and 50-percent reduction in coverage. The only States that do not have a reduction in coverage are the white ones. There are three or four States that are not seeing deep cuts in Medicare Advantage benefits.

Those who say—like the President who said it was one of his goals—if you like what you have, you can keep it—not if you live in one of the States that is not in white on this chart because your benefits will be cut.

Mr. ALEXANDER. I wonder if I might ask the Senator from Idaho to go back over a point he made a moment ago because he went over it quickly and it is such an important point and one reflected by the chart behind him about what he just said. Repeatedly we are told that seniors won't lose benefits if you cut nearly $½ trillion in Medicare. So if you could take

a moment—I believe you were in the Finance Committee markup where the bill was being written that was offered by the distinguished Finance Committee chairman, and I believe you were talking to the head of the Congressional Budget Office, who is often cited by our friends on the other side as the nonpartisan authority for exactly what the bill does, and you asked him whether the benefits of Medicare Advantage recipients would be cut. Would you describe that in a little more detail so people understand exactly the scenario?

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

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

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

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

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

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

Referring to Senator CASEY of Pennsylvania—

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

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

Mr. HATCH. That is right. Go ahead.

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

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

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

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

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

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

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

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

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

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

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

C–SPAN, keep waiting. We are going to try to get you in.

Mr. GREGG. If I could ask one more question because I have been listening to this debate, and I came over because I wanted to participate a little. I think it has been an excellent and informative debate.

I have been looking at the numbers here, and I know the numbers are big—big—in this first 10-year period—almost $500 billion in reductions in Medicare spending. But I think the point we need to make is that it doesn't end there. It doesn't end there. Those Medicare spending reductions go on into the next decade, too, and over the first two decades of this bill, Medicare spending reductions will account for $3 trillion—$3 trillion. How can anybody argue against what the Senator from Idaho said, which is that this translates into real reductions in Medicare benefits?

Mr. MCCAIN. Isn't the vitally important point in this discussion that this massive mountain being carved out of Medicare is not being used to save Medicare? It is creating a huge new entitlement program. So here we are with Medicare going broke in 7 years, and we are taking money out of it in order to create a new program. That is the crime that is being committed here.

Mr. GREGG. The Senator is absolutely right. And the new program, by the way, will not be solvent either. So we are compounding the insolvency of the future, and we are passing that on to our children.

Mr. HATCH. We are taking $½ trillion out of a program that is going to be insolvent before the end of this decade and we are giving it to another program that is already insolvent.

Mr. GREGG. That will be insolvent.

Mr. HATCH. That will be insolvent. It is almost insane what they are doing. And they wonder why the American people are having such a difficult time, why we have 10 percent unemployed, why the underemployment is 17 percent in this country. Those are people who are trying to get part-time jobs because they can't get full-time jobs. So 17 percent is the real number.

This whole program is about helping low-income people and minorities, when you stop and think about it. That is what Medicare Advantage does. As the distinguished Senator from Arizona has said, they can't afford these supplemental policies on which AARP will make a lot of money if they can kill this program. There are a lot of gaps in traditional Medicare benefits, including high cost sharing and no out-of-pocket limits. That is why 89 percent of seniors have some form of supplemental coverage on top of Medicare. For many low-income Americans and minorities, Medicare Advantage is the only way they can afford the supplemental coverage.

I compliment all of my colleagues here on the floor—the distinguished Senator from Arizona; the distinguished Senator from Idaho; the distinguished Senator from Texas; our only

doctor on the floor right now and one of only two in the Senate, Senator BARRASSO from Wyoming; and, of course, our leader in the Senate, both on the Budget Committee, Senator GREGG and, of course, Senator ALEXANDER. You guys have really summed this up.

Mr. MCCAIN. Could I say again that we have had spirited debate and discussion on this floor, but it is clear the majority of the American people do not support the proposal that is before us, and they do not support meeting in private, mostly in secret, closed negotiations.

Again, I renew our offer to the Democrats and to the administration: Let's get together in a room with the C–SPAN cameras and any other outlet, and let's sit down and do some serious negotiations on the areas we can agree on, which there are many, and let's save Medicare, let's fix this system, and let's do it together in the way the American people want us to—in a bipartisan fashion, not behind closed doors, so the American people can see us work together for a change.

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

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

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

Mrs. HUTCHISON. And 8.5 million seniors would be deprived.

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

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

Mr. GREGG. Well, my view is this: First off, we know a couple of facts—that we grow the government by $2.5 trillion over a 10-year period when this bill is fully implemented. We also know the tax increases during that period will be approximately $1.2 trillion, tax increases and fees, and they are not going to fall on the wealthy, they are going to fall on the small businessperson trying to create the extra job. We also know there will be an entire sea change in the way people get their health care, that the government will be stepping in between you and your doctor and basically making a decision as to what your doctor can tell you you can have for health care, what the provider will tell you you can have for health care.

There is something that hasn't been discussed much. We know the innovations in health care which have done so much to make America the best place to get health care in the world and which have put us on the cutting edge of drugs that have improved the lives of millions of people, not only in the United States but across the world, will be significantly chilled because there will not be an interest in investing capital in a market that is so controlled by the government.

In the end, it is fairly obvious to anybody who has been around this place that there isn't going to be $3 trillion in reductions of Medicare spending over the next 20 years and there isn't going to be $500 billion in Medicare spending cuts in the next 10 years. So all that spending is going to fall on the backs of our children in the form of debt.

We already have a nation that is on an unsustainable path under the present budget scenario without this health care bill. Our deficits are $1 trillion a year, on average, for the next 10 years. That is without this bill. Our public debt goes from 35 percent of the gross national product to 80 percent of the gross national product. We become insolvent at the end of this decade—not this decade but the decade starting today, 10 years from today. That is aggravated dramatically by exploding the size of the government under this bill rather than taking the step-by-step approach that has been proposed by our side to reform health care, to make it more effective and make it deliver more services to more people at a better cost.

A number of times I have heard people on the other side of the aisle get up and say that CBO says this bill reduces the cost of health care spending to the Federal Government. It is just the opposite—just the opposite. The CBO letter specifically said that the cost to the Federal Government of health care goes up—goes up—under this bill in the 10-year period. So this bill does not turn down the cost of health care, it does explode the size of government, it does put the government into the business of managing your health care, and as a result, I think it is going to reduce the quality of life of our children.

Mr. HATCH. Will the Senator yield on that point?

Mr. GREGG. I do not have the floor.

Mr. MCCAIN. Go ahead.

Mr. HATCH. The Senator has pointed out he does not believe they can afford all these programs. The Senator is not suggesting this is a game, is he?

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

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

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

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

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

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

Mr. GREGG. Absolutely.

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

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

Mr. ALEXANDER. I would direct my comment to the Senator from New

Hampshire, too. The President of the United States said something a few weeks ago that I thought was profound and that I agreed with, he said this debate is not just about health care; it is about the role of the Federal Government in the everyday lives of the American people. I believe he is exactly right about that, which is why so many Americans are turning against this bill.

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

Mr. GREGG. I think the Senator from Tennessee has once again hit the nail on the head. I respect the President's forthrightness. The President has said very simply he believes that prosperity comes from growing the government. When this bill passes, we will see the largest growth in government in the history of our country. This is going to be 16 percent of our economy basically managed by the Federal Government. You are going to see the Government explode in size. Does that lead to prosperity? I don't happen to think it does. It certainly doesn't lead to prosperity if along with that massive expansion in the size of the government you are going to see your deficit go up significantly, your debt go up significantly, or the tax burden go up significantly, which reduces productivity, or if you take a large segment of our society, our seniors, 35 million today, 70 million by the year 2019, and say to them they are not going to have the ability to have a solvent Medicare system because the way that system might have been made more solvent is now being used to create a brandnew entitlement, a massive new entitlement for a whole group of people who never paid for an insurance policy and never paid into the Medicare insurance fund.

I think the Senator has touched the base. We have seen automobiles, we have seen financial institutions, we have seen the student loans, and now we are seeing health care all taken over by the government or partially taken over by the government. Clearly the goal is, as the President said, expand the size of the government, create prosperity, use the European model. I don't happen to be attracted to the European model. I think the American model works better where you have a government you can afford and give entrepreneurs a chance to go out and take risks and create jobs.

Mr. MCCAIN. Senator HUTCHISON will conclude.

Mrs. HUTCHISON. We have been talking about Medicare Advantage and losing this great option for lower income seniors, which is so important. I was reminded that we have not even talked about the $135 billion that would be taken out of hospitals in this bill. These are the care providers. We are talking about taking away benefit options in eye care and dental care and hearing aids, sort of basic things seniors need, but also undercutting the hospitals that treat them, so the care provided in the hospitals themselves would also have to be cut back.

It does not pass common sense to cut Medicare in order to create a new big entitlement program. We have all said that Medicare is on life support anyway, everyone understands that. So you take almost a $½ trillion out of a program that is working for seniors, that gives options to seniors such as Medicare Advantage, and you take away their care to pay for another entitlement program that is not specifically designed for them.

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

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

Mr. BAUCUS. Mr. President, if I may, I ask unanimous consent that we extend for an additional hour the period for debate only with no further amendments or motions in order during the hour; and that the time be equally divided between the two sides, with the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

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

Mr. BAUCUS. I believe there is 3 minutes remaining on the first block, on the majority side?

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

The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I ask unanimous consent to be added as a cosponsor to the Coburn amendment No. 2789 requiring all Members of Congress to enroll in the new public health insurance option. I wish to add my name to Senator COBURN's amendment. Seventeen years ago when I first ran for Congress I promised I would pay my own health insurance until Congress paid health insurance for everyone. I have paid out of my pocket since then. I look forward with great eagerness to joining the public option as soon as it is available.

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

The ACTING PRESIDENT pro tempore. And 15 seconds.

Mr. BAUCUS. OK. I want to make three basic points. The Senator from Arizona talks about, gee, all these Medicare Advantage plans have dental and vision coverage. He goes on to say, so do Members of Congress.

The fact is that is not automatically true. The fact is Members of Congress choose among various private plans. Some plans offer dental and vision, some do not. Aetna is a company that Members of Congress could choose from under FEHBP and others that Members of Congress can choose from. Those do provide dental and vision coverage. But there are others—I think Blue Cross and Blue Shield does not provide dental and vision coverage.

I make that point because this is exactly what we are trying to set up in these exchanges. People could participate in the exchanges, where they would buy private coverage and they could choose among various private plans which coverage they want. Do they want a plan that covers dental and vision, or not? That is exactly what we are trying to do in the exchange, as is the case for Members of Congress. Medicare Advantage plans do provide dental and vision. I think that is great.

I see my time has expired. At the appropriate time I wish to go into greater detail and explain why what we do in this bill I think makes eminent sense.

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

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

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

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

But I want to leave that debate for later. I want to visit with my colleagues now about Medicare Advantage. Mr. President, 64,000 seniors in Iowa and 11 million seniors nationwide do not care about the gobbledy-gook type words we use here in town, as legal as they are—''guaranteed benefits'' on the one hand and the words ''additional benefit'' on the other hand. In other words, guaranteed benefits or,

as the other side wants us to believe, somehow additional benefits provided under Medicare.

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

I know that to be the case. I have at least 1,000 letters I have received since last summer on this point. But I want to read one from Miss Purificacion S. Gallardo of Iowa City, IA.

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

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

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

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

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

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

The ACTING PRESIDENT pro tempore. The Senator from Texas.

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

What about the cuts to care provided in a hospital? Hospitals that treat a large share of low-income seniors get an extra payment from Medicare. Medicare already makes reduced payments to providers, to doctors but also to hospitals, to hospice, to nursing homes, and home health agencies for senior services. And yet proposed is a cut of almost $500 billion. All of these serve our seniors in such great ways. Look at the cuts, almost a $½ trillion over 10 years. This is not sustainable. We cannot take away from Medicare, cut services, cut reimbursements to providers. What is going to happen to a hospital? What is going to happen to a hospital in a rural area, especially that is barely hanging on right now because they are trying to make ends meet in a more expensive treatment area and they lose the added payment that would make them whole in the treatment of low-income seniors?

The Texas Hospital Association estimates that $2 billion will cut in payments to hospitals for treating a large volume of low-income Medicare patients, $2 billion out of our economy. Mr. President, 254 counties in Texas, more than one-fourth, do not even have an acute care hospital within their boundaries. With these kinds of cuts to rural hospitals, we are talking about losing more hospitals. There is no doubt about it. They are already struggling. Why would we pay for health care reform on the backs of our senior citizens? Why would we take away a program they have that is tailored for their needs in order to pay for another big government program that is going to cost $2.5 trillion, most of which is going to be added to the deficit, added to the debt, and we are already hitting the ceiling of the debt at $12 trillion? We are in a very tough financial time. We are in a time that is hard for people who have lost jobs, hard for seniors stretched to make ends meet, hard for hospitals serving seniors and not getting paid the full cost of the treatment. Yet we are talking about cutting these services.

Of the $135 billion in Medicare cuts to hospitals, $2 billion is for the reimbursement rates that will no longer be making hospitals whole. I went to the major medical centers in Texas—in Dallas, Houston. Then I went to rural areas. It is the topic of conversation. Anyone who is dealing with a hospital in a rural area, they are all saying: What are you doing?

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

I understand my time has expired. I think the Senator from Oklahoma has the rest of the time on our side.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma.

Mr. INHOFE. Mr. President, I thank the Senator from Texas. I yield myself the remainder of our time, which I understand is until 10 after the hour.

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

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

meets the approval of bureaucrats in Washington and of politicians. The bill makes it a crime not to have health insurance. If you don't get it, you get taxed.

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

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

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

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

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

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

> I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

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

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

Now, that is if you do have health insurance. What if you do not have health insurance? You still get taxed. Under this bill, you get taxed if you do not carry health insurance, as a penalty. Where does this burden fall? You guessed it: middle-class Americans. CBO has said that half of the Americans affected by this provision make between $22,800 and $68,000 for a family of four. That is middle-class America.

If you take prescription drugs, you get taxed. That is another area. According to the JTC and CBO, new taxes in the bill applied to the provision of prescription drugs will end up raising the cost of those drugs. So you are taxed again.

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

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

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

> The decision of who needs a pacemaker could be complicated, particularly the decision to put in a pacemaker on someone we might consider quite elderly. But it's a false economy to deny putting one in because of their risk of falling (breaking a hip or shoulder). In the case where they fall, the costs become quite high. The cost of a pacemaker pales in comparison to the cost of a stroke or multiple fractures.

A pacemaker, by the way, costs about $5,000 and lasts about 10 years. That is $500 a year—not a bad deal. So I think this is a quality-of-life issue that we could lose with the Democrats' government-run health care schemes.

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

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

Basically, the bill says that people making $200,000 a year are going to pay an additional payroll tax called the

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

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

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

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

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

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

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Montana.

Mr. BAUCUS. Mr. President, I understand we are now under the order where there is a half hour allocated to the majority side; is that correct?

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

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

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

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

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

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

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

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

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

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

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

> First, we estimate that in 2009 Medicare pays about $12 billion more for enrollees in Medicare Advantage plans than it would if it were fee-for-service Medicare.

Second:

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

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

MedPAC says:

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

Well, that is pretty obvious.

In addition, MedPAC goes on to say:

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

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

Further quoting:

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

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

In addition:

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

A couple of more quotes from MedPAC:

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

That is an interesting statement. The additional payments hasten the insolvency of the Medicare Part A trust fund by 18 months.

Going with quotes from MedPAC:

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

In addition, continuing the quote:

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

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

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

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

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

So when we see these big crocodile tears, and we hear Medicare Advantage is being cut; when we hear all of these dramatic statements that so much is going to be taken away from seniors because Congress is cutting Medicare Advantage, the fact is, we are reducing the rate of increase in Medicare Advantage payments by only about 10 percent, and under this legislation about $1.7 trillion will be spent on Medicare Advantage plans. Remember, MedPAC says these are overpayments. MedPAC says this 10 percent reduction is what they should be paid.

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

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

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

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

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

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

Bottom line, I just wish to say I am not opposed to Medicare Advantage plans. Frankly, I think it is good we have Medicare Advantage plans. Medicare Advantage plans provide the competition to Medicare. They help keep the system on its toes. But we have an obligation as Members of this Senate to the taxpayers and to seniors to cut waste and to cut overpayments in a way that does not harm beneficiaries. These are reductions recommended to Congress by the best advisory board of experts we could find. They didn't just come out of thin air and Members of Congress thought this up. This was recommended to us by the MedPAC advisory board.

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

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

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

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

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

The PRESIDING OFFICER. There are 13½ minutes.

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

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I wish to thank our distinguished chairman of the Finance Committee

for debunking what has just been said on the Senate floor by our colleagues on the other side of the aisle, laying out the facts of what is and is not happening with Medicare Advantage. I wish to build on that as well.

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

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

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

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

I find it interesting that a few years ago our colleagues quoted AARP all the time when we were debating the Medicare prescription drug bill—I would guess that every single one of our Republican colleagues used their support in putting forward their bill—and now they are trying to disparage AARP, which is a very credible organization, because they don't agree with what AARP is saying. But I think the millions of people who belong to AARP will be listening to what they are saying about the fact that we are not, in fact, cutting the guaranteed Medicare benefits.

In addition to that, we have the Alliance for Retired Americans and the National Committee to Preserve Social Security and Medicare all saying they support what we are doing and they have debunked the Republicans' scare tactics point by point.

So what is happening here? The reality is that colleagues on the other side of the aisle, since the inception of Medicare, have been fighting even the existence of Medicare. It was Democrats and a Democratic President in 1965 who passed Medicare over their objections. The same arguments we are hearing today, we heard then. Now everyone sees that Medicare is a great American success story. But we have seen so many efforts.

In the 1990s, when I was a Member of the House, Speaker Gingrich said in his Contract With America in 1994 that they wanted to come in and change Medicare, they couldn't directly do it so they would do it through the back door and let it ''wither on the vine''—those famous words that we heard at that time in terms of trying to privatize Medicare, which is what I believe Medicare Advantage really is.

Then, recently, in the debate on the floor of the House of Representatives, we had 80 percent of the House Republicans support an effort to do away with Medicare at all, as we know it, as a guaranteed benefit. Instead, give vouchers to seniors to buy from private for-profit insurance companies. We know the reality of this. This is about the for-profit insurance industry that right now is receiving overpayments. Whether it is the CBO or MedPAC—any analysis will say they are receiving overpayments right now, and we are trying to ratchet that back.

What is happening? Why should folks care? Of course, taxpayers care about overpayments. We have maybe 15 to 20 percent of seniors right now who are in the Medicare Advantage Program. We have been told by the Budget Office that 80 to 85 percent will see their premiums go up to pay for overpayments to for-profit insurance companies. That is not fair. The vast majority of seniors and people with disabilities would see their premiums go up under Medicare to pay for for-profit insurance companies that try to get a piece of the action under Medicare.

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

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

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

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

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

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

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

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

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

We are rewarding Medicare Advantage in the bill, as the chairman pointed out. Based on performance and quality, we actually give bonuses in Medicare Advantage—contrary to the arguments you have heard by those who are heralding Medicare Advantage, despite the fact that the very companies who argued for it to begin with, promised they were going to prove how they could reduce costs and be more efficient. In fact, today, it is quite the opposite. Right now the government pays these Medicare Advantage insurance companies $1.14 to do the same thing for seniors that Medicare does for $1. That is basically, on average, what it amounts to.

The question is, can we reduce the cost of the overpayments, which are basically ending up in the pockets of insurance companies? There is nothing wrong with profits in private companies, but let's declare them what they

are. This is not traditional Medicare. They are private companies that are anxious not only, I presume, to provide benefits to their beneficiaries, but they are also looking to make a profit. There is nothing wrong with that, but since the premiums were set by statute, and we have an obligation to try to keep our costs down, we are trying to do so because the promises that were made have not been kept. The costs are vastly exceeding the promises made.

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

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

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

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

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

I know the chairman of the Finance Committee made that point. Seventy-five percent of the increase in gross profits came from the Medicare Advantage plans. These profits come out of the pockets of the American taxpayer because of the subsidies and, of course, the Medicare beneficiaries who are paying those extra dollars every year, without receiving any of the benefits at all. Our bill will protect and strengthen Medicare and extend the life of the trust fund, as you have heard over and over again. That is not a fact to dispute. That is a fact. We extend the life of the Medicare Program. Part of the way our bill adds to the use of Medicare is to eliminate wasteful overpayments. These are overpayments far beyond what was anticipated when the program was written.

As I mentioned a moment ago, the government pays insurance companies in the Medicare Advantage Program $1.14 to do the very same things for seniors that traditional Medicare does for $1. So those are the overpayments we are trying to rein in. There is no evidence these wasteful overpayments do anything to improve the care of our seniors. At the same time, they speed Medicare's descent into bankruptcy and raise premiums for all Medicare beneficiaries.

Our bill would end that waste and use the money we save to help seniors pay for prescription drugs by closing the doughnut hole. For the second time in less than a week, our friends on the other side are using these tactics to halt progress completely, fighting for these profits and overpayments that, again, come out of the hide of taxpayers and our elderly.

If you look at this chart, if you extend to 2019, almost 10 years from now, what is the difference between what our bill does and what those who want no change do? The difference is $20 billion. In the post-reform period, in 2019, it is $183 billion going to Medicare Advantage. What the opposition wants is to hold it at $204 billion in 2019. That is $20 billion. That is the savings we are looking for in order to reduce overpayments and provide those resources to the elderly so they can afford prescription drugs.

If you want to side with these companies—they are still going to make a profit. This will not deprive them of that. The profit margins will be far more realistic and it will reduce subsidies, as well as overpayments being made by the elderly who receive nothing from this program at all.

Let me make my case on this point. Senator STABENOW listed the guaranteed benefits under Medicare. The chairman did it as well. Also, we add benefits as a result of our bill. In addition to the inpatient hospital care, doctor office visits, lab tests, kidney dialysis, emergency care, occupational therapy, organ transplants—all of these issues—we also do things in our bill that are not available presently. We reduce the size of the Medicare doughnut hole. That is an added benefit that does not exist today. We reduce premiums to pay for drugs and medical care. We eliminate the copays. What an advantage that is here. Ask yourself whether you would like to eliminate copays or watch private companies make an additional $20 billion in 10 years. Which is the better choice? Ask the overwhelming majority of seniors which they would rather have—an elimination of the copays they are paying today, or continue to provide excess profits for the companies here that have made so much under the Medicare Advantage Program.

Lastly, of course, and most important, we help keep Medicare solvent. People say: Give me some examples on why the differences exist between Medicare and Medicare Advantage. I have a couple of examples from my home State that I think highlight the point. These come from the Center for Medicare Advocacy, or CMA, which is a nonprofit organization, as my colleagues know, that does casework on behalf of individuals who need assistance dealing with Medicare Advantage plans. They provided two cases from my State. I presume most of my colleagues could find cases in their own States.

A woman living in Madison, CT, a shoreline community in Connecticut, had Lou Gehrig's disease, ALS. We are all familiar with ALS. We know the stories people go through with that disease. She was in a Medicare Advantage plan. She was denied coverage for home health care because she was said to be ''stable.'' That was the quote, ''she was stable.'' That is not a valid reason for denial, and she was hardly stable with ALS. CMA, the Center for Medicare Advocacy, had to go to Federal court to get her care covered despite firm written support regarding her medical condition from her doctors.

Here is a woman under Medicare Advantage with ALS being declared by Medicare Advantage ''she was stable.'' Her doctors said anything but the case.

When my friends talk about rationing of care under the present system, here is Medicare Advantage, a private firm, making a medical decision that should have been made between her and her doctor. They eventually got it overturned, but they had to go to Federal court to get it overturned. That would not have happened under Medicare. If she had been under Medicare, she would have gotten that help, no questions asked.

When people say there is no distinction, this is a live case.

Let me give the second one. A woman from Vernon, CT, and her husband traveled to Florida to visit their daughter living there. When she got to Florida, she fell down and sustained some physical injuries. While being treated at a Florida hospital for her injuries, it was discovered that she had a brain tumor, the reason she had the fall. She had no idea of this beforehand.

The Medicare Advantage plan covered treatment for the fall as an emergency—which Medicare Advantage plans must cover, even out of network, by the way—but not any diagnosis or treatment for the brain tumor.

The woman had another daughter who was a nurse who lived in Utah. So they traveled from Florida to Utah where she went for the cancer treatment for the brain tumor. While undergoing chemotherapy, this woman had a

life-threatening reaction to one of the medications from which she almost died. The Medicare Advantage plan denied coverage for all of this care because it was out of network. She was in Utah. They said no, leaving the client and her husband with $100,000 in bills.

Again, the Center for Medicare Advocacy went to court and battled against this decision. They were successful in recovering $90,000 out of the $100,000. This woman is now deceased, but she and her family were left with over $10,000 in bills, all of which would have been covered under traditional Medicare, but she had gone into a Medicare Advantage plan. In both instances, they would have avoided having to go to Federal court, having to fight as hard as they did, going through the trauma and turmoil. It is bad enough you have to wrestle with cancer or wrestle with a brain tumor, but then you get saddled with $100,000 in bills and Medicare would have taken care of them. This Medicare Advantage Program disadvantaged her in the process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The third part of his amendment is particularly important. Many of our colleagues have come to the floor in the last few days to claim the CLASS Act will be a long-term drain on the budget. It is not true. Thanks to our colleague from New Hampshire, Senator GREGG, the CLASS Act will be required by law to be solvent for 75 years. This was not in our original proposal. It was added in the HELP Committee markup by Senator GREGG, and I thank him for it.

The Gregg amendment was unanimously adopted in our markup. CBO says it produces $72 billion in savings for the Federal Government over the first 10 years of its existence and it will save nearly $2 billion for Medicaid.

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

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

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

Lastly, I ask unanimous consent to be included as a cosponsor, along with my colleague from Maryland, Senator MIKULSKI, of Senator COBURN's amendment No. 2789 which adds Members of Congress to the public option.

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

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

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

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

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

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

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

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

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

Mr. ENZI. Yes, Mr. President, I wish to speak.

The PRESIDING OFFICER. The Senator from Wyoming.

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

Mr. BAUCUS. I might modify that so this side gets the next 30 minutes after that.

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

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

I thank the Senator from Connecticut for setting up my speech so well. He said there was not anyplace that anybody can show any decline in guaranteed benefits. With what I am about to say, I will try to do that. Of course, the words ''guaranteed benefits'' do not show up anywhere in what we are doing. ''Benefits'' does but not ''guaranteed benefits.'' In my opinion, getting to be in a nursing home or being able to see a doctor, some of those ought to be considered guaranteed benefits. I will get into that a little bit in my speech and cover some of these areas that I think are very important to seniors. I am opposed to the $½ trillion of Medicare cuts in the Reid bill that are not going only to solve Medicare.

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

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

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

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

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

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

As the senior Senator from Tennessee noted yesterday, it is the Medicare cuts in the Reid bill that are actually scaring seniors. Medicare beneficiaries understand that if providers are no longer able to take Medicare patients, they—the seniors—will not get care. A lot of grandmas and grandpas have figured it out, and they are not going to stand for it.

The chairman of the Finance Committee has repeatedly said this bill will not cut or reduce any guaranteed Medicare benefit. That statement seems to ignore what this bill will do to providers. If a Medicare patient cannot get into a nursing home, they do not have nursing home benefits. If they can't find a home health aide willing to take Medicare patients, they do not have home health benefits. So the promise for coverage, when you can't get a doctor to see you, is not health care. You don't have benefits if you can't get a provider to treat you. Unfortunately, that is exactly what this bill will do.

Some of my Democratic colleagues have also attempted to justify the Medicare cuts in the Reid bill by arguing that many of the trade associations

representing health care providers have endorsed this bill. They are correct that several Washington-based trade associations and their lobbyists have endorsed the Reid bill. It is probably worth exploring why some of the groups have chosen to endorse this legislation.

In some cases, motivation is obvious. Some drug manufacturers are clearly motivated by self-interest and greed. They negotiated a secret deal with the White House that will actually increase what Medicare spends on brand-name drugs—brand-name drugs. They didn't touch the generics. They are interested in the brand-name drugs.

Under the terms of their deal, the drug manufacturers will provide discounts on brand-name prescription drugs when the seniors are in the Medicare coverage gap—known as the doughnut hole. They make the payments directly to the customer. It doesn't go through Medicare but directly to the customer. That way they can maintain the customer contact and keep them addicted to the brand name.

Generics are cheaper. A lot of people, when they go to the doughnut hole, switch to generics because that saves them money, and it saves us money. When they get through the doughnut hole, they will stay with whatever they are on while in the doughnut hole. So if they are forced to stay on a brand name to get a little extra discount as they go through the doughnut hole, they will stay with the brand name when the taxpayers are paying for it when it goes above the doughnut hole, which is the rest of the year. That could be a huge number. So while it looks generous by the drug companies, beware; their generosity is suspect with what they will make when it gets through the doughnut hole.

Under the terms of the sweetheart deal between the White House and the drugmakers, discounts are provided for these brand-name drugs. This will encourage seniors to continue to get those more expensive drugs, and it will actually cost the taxpayers $15 billion because the deal will actually increase Medicare costs.

In other cases, provider groups were promised special deals if they agreed to support the Reid bill—or whatever bill we were working on at that time. For instance, recent press reports have described how the American Medical Association was promised a permanent fix to the Medicare payment formula for doctors if they agreed to support this bill or a 1-year fix if there was an end to junk lawsuits. Under current law, doctors' Medicare payments are scheduled to be cut by more than 40 percent over the next decade. That is already in place. That is not a part of the bill. The cost of fixing the flawed government-mandated formula will be more than $250 billion. We know that because we have debated it on the Senate floor, and we decided we were going to have to pay for that if we were going to do it.

So let's see, $464 billion in Medicare money we are using on other things. That is why I keep saying Medicare money only ought to go to Medicare benefits, and that $250 billion for the doctors' fix might make it possible for people to see the doctors.

I can understand why doctors want to fix this flawed government price-control system—and that is what it is because they are telling the doctors what they can charge a customer, regardless of how long a time it is going to take them to take care of that patient. For a lot of them, they have discovered it costs more than what they are able to get. If they continue to do that, they have to go out of business. That is kind of the small business philosophy: You take in less money than what it costs to be in business, and you are out of business. So I don't think they like that kind of a government price-control system.

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

I was talking to a friend of mine from Florida who said: Every time you call a doctor now, they say: Are you on Medicare? If you say yes, they say: We are not taking any new patients.

If you can't see a doctor, you don't have a benefit. It shows the exact problems that result from letting government bureaucrats use price controls to set payment rates. What I don't understand is why the AMA continues to support the bill when they got nothing for their deal. We didn't fix the $250 billion problem, and we haven't fixed the junk lawsuit problem.

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

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

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

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

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

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

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

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

Given the recent experiences that doctors have had with Medicare price controls, this is not an outcome that bodes well for America's health care providers or their patients. I remind everybody that in August there was an uproar, and that uproar continues. We don't notice it as much because we are not going to get to go home this weekend to talk to our constituents. That

might be by design because we already know what our constituents are saying.

They are saying: This bill is a bad deal for us. Where is the promise that you were going to cut costs for us? Where are the other promises that were made with this health care reform?

I would mention that the CBO found that premiums in the individual market will rise by 10 to 13 percent more than if Congress did nothing. That is CBO. Family policies under the status quo are projected to cost $13,100 on the average, but under this health care bill it should jump to $15,200. That is not very good news for the people in my State or any other State. No big cost rise in U.S. premiums is seen in the study, said the New York Times.

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

Yes, lowering costs is what health care reform is designed to do—lowering costs.

But then he said: And it will achieve this objective. Except that it won't.

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

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

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

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

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

The Reid bill has $371.9 billion in new health taxes that are apparently not a new cost because they would be passed along to consumers. Or perhaps they will be hidden in lost wages. This is the paleoliberal school of brute force wealth, redistribution and a very long way from the repeated White House claims that reform is all about bending the cost curve. The only thing being bent here is the budget truth.

Moreover, CBO is almost certainly underestimating the cost increases. Based on its county-by-county actuarial data, the insurer WellPoint has calculated that this bill will cause some premiums to triple in the individual market. I don't go by WellPoint, I go by what I found out in Wyoming itself and that is an accurate picture, particularly for the young people in our State. Those who are young and healthy will see a 300-percent increase. I think they are going to notice that. I don't think they are going to be happy with it. Other associations have come to similar conclusions. The reason for that is the community rating, which forces insurers to charge nearly uniform rates regardless of customer health status or habits. Habits is an important one on that. CBO does not think this will have much of an effect, but costs inevitably rise when insurers are not allowed to price based on risk. That is why today some 35 States impose no limits on premium variation and 6 allow wide differences among consumers.

That is not just WellPoint that is saying that. I have some peer-reviewed documents that also show that same thing from people from different colleges. They have found that the State community rating laws raise premiums in the individual market by 21 percent to 33 percent for families and 10 to 17 percent for singles. In New Jersey, which also requires the insurers to accept all comers, so-called guaranteed issue, premiums increased by as much as 227 percent.

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

The political tragedy is that there are plenty of reform alternatives that would reduce the cost of insurance. According to CBO, according to the Congressional Budget Office which we quote a lot, they did an evaluation on the relatively modest House GOP bill. The Republicans in the House were limited to one amendment. There were three amendments total in a 1-day debate and passage of the health care bill over there. That roused a lot of people in America, too. If you only get one amendment, they had to do what we have avoided doing. We have four different bills out there that solve what the President said he wanted solved. That is not counting the Wyden-Bennett bill that also solves what the President said, that is not included in this bill.

What the House put together—it is relatively modest, but it would actually reduce premiums by 5 percent to 8 percent in the individual market in 2016 and by 7 to 10 percent for small businesses. It would not increase the premiums, it would decrease the premiums.

The GOP reforms would also do so without imposing huge new taxes. We have concentrated in the last few days about talking about the Medicare money that is being stolen to provide for the changes. We have not talked yet about the extra taxes that are going to be put into place. That is the other half of the package. But the Democrats do not care because this bill, they say, is about lowering costs. No, it is about putting Washington in charge of health insurance at any cost.

I see the Senator from Wyoming is here. We have 10 minutes remaining on our time. If the Senator wishes to make some additional comments? He and I have been traveling in Wyoming.

The PRESIDING OFFICER. The Senator has 7½ minutes remaining.

Mr. ENZI. I yield the time to my colleague.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, I ask my colleague from Wyoming, with whom I have the privilege of serving, I saw a large story in USA Today. This story says ''Senate Keeps Medicare Cuts in the Bill.''

What it says is:

> Senate Democrats closed ranks Thursday behind $460 billion in politically risky Medicare cuts at the heart of health care legislation.

It goes on to say:

> Approval would have stripped out money to pay for expanded coverage to tens of millions of uninsured Americans.

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

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

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

benefits or whatever it is, they are saying, yes, we are being cut.

Mr. BARRASSO. Mr. President, I would say when my colleague from Wyoming and I held townhall meetings around the State of Wyoming, people have said don't cut our Medicare. Yet what I see this bill doing is cutting our Medicare and specifically, right now, there are thousands of people in Wyoming who are on a program called Medicare Advantage. There is an advantage to this program. That is why so many Americans have signed up for the program.

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

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

The bill in front of us, as I see it—I ask the Senator from Wyoming—is a bill that is going to cut $120 billion from Medicare Advantage, the program the people in our State like?

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

Mr. BARRASSO. I actually heard somebody say Medicare Advantage is not Medicare. But if you turn to the Centers for Medicare Services' 2010 Official Government Handbook—we are going to go into 2010 next month. If you go to the official handbook for 2010, and the handbook is called ''Medicare And You,'' it says a Medicare Advantage plan is ''another health coverage choice you may have as part of Medicare.'' People who actually look at this choose this. They make the choice because they say this is a good deal for me. That is what Americans want. They want to get value for their money.

A recent poll said, in terms of Americans, when they send money to Congress, how much of that do they get back in value? They think about 50 cents on the dollar. That is a national Gallop Poll. They have been polling on this for a long time and it is the highest number ever of what Americans think, in terms of the fact that they are getting very little value for their tax dollars. They see games being played. That is what I hear when I have telephone townhall meetings in Wyoming. They know Senator REID's bill steals $464 billion from Medicare. They know it raids the health care program they depend upon, not to make Medicare stronger, not to make Medicare more solvent, but as my colleague from Wyoming tells me, to create a brandnew entitlement program. They are raiding Medicare to start another government program that is itself going to be insolvent.

I ask my colleague from Wyoming, are you seeing what I am seeing?

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

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

We know we need to do some changes. But this massive bill, this 2,000-page bill that weighs 20 pounds, is not the right change we need. For our seniors, people who rely on Medicare for their health care, to absolutely raid $464 billion from Medicare, almost $½ trillion, there is a point where more people—the baby boomers, more and more people are added to the rolls every day. To raid this program to start a whole new government program is not the right prescription for America. It is not what our seniors want. It is not what they signed up for. It is not why they are choosing Medicare Advantage. It is because it is a choice they make and that is why we right now have 11 million Americans who are on Medicare Advantage. We have 11 million seniors—that represents almost one-quarter of all Medicare patients in this country.

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

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

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

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

Under present disability formulas, which are basically income-replacement bills, in order to get some help if you are disabled, you almost have to impoverish yourself to qualify and then be restrained about how much you can actually earn, if you want to continue to work. So while it has been a good program and certainly has helped a lot of people, in a sense there are catch-22s in it, that to qualify for it, you have to divest whatever you have acquired or earned and impoverish yourself. Then, even though you may be capable of continuing to work, you are limited on how much you can actually earn under those programs.

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

The question was, how could we do this, particularly in light of the fact that we don't want to necessarily be adding a cost to taxpayers. It was his idea to come up with a totally voluntary program that individuals would have to contribute to out of their own pocketbooks, not out of taxpayers pocketbooks, by putting aside resources on a monthly basis over a period of years—5 in the case of this bill—where the plan would become vested and then to contribute that amount thereafter. Then, in such case if you found yourself disabled—and there are criteria that would determine whether you met those thresholds—you would then qualify, based on the fact that you have paid your own money into this program continuously, without exception, to receive at least about $75 a day, providing assistance to you so that you might get along and be able to continue to operate without having to impoverish yourself and put limitations on your work. At $75 a day, that would provide over $27,000 a year for those individuals who meet it. Again, entirely voluntary, your money, not public money—no taxpayer money goes into the plan.

Five million people under the age of 65 living in the community have long-term care needs, and there are over 70,000 workers with severe disabilities in the Nation today who need daily assistance to maintain their jobs and their independence. Long-term care supports and services are an area that is not currently affordable or accessible for millions of our fellow citizens. It is estimated that 65 percent of all those who are 65 or over today will spend some time at home in need of long-term care services, for which average costs run at least $18,000 a year.

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

Many people who need long-term services and supports rely on unpaid family and friends to provide that care. They have children or grandchildren who are around to provide that kind of assistance. A lot can't, of course. But ultimately many of these individuals have to impoverish themselves to qualify for Medicaid. We know what happens. They transfer the house, their assets. They shove everything over to their children or someplace else so that they qualify for that title XIX window. They become desperately poor, so they can then qualify for Medicaid, which remains the primary payer for these services. The CLASS Act is designed to avoid that, if we can, in as many cases as possible by providing a lifetime cash benefit—voluntary, totally paid for by the beneficiaries—that offers seniors and people with disabilities some protection against the cost of paying for long-term care services and supports and helps them obtain services and supports that will enable them to remain in their homes, reside in their communities, and, in many cases, continue to work.

Let me tell you how the program works. The program is a totally voluntary, self-funded insurance program with enrollment for people who are currently employed. Affordable premiums will be paid through payroll deduction, if the individual's employer decides to participate. It is totally voluntary, nothing required whatsoever. If the employer does not want to participate, the employee would have to find some other way. If the employer decides to allow a payroll deduction, they can do that. Participation by workers, again, is entirely voluntary. Self-employed people or those whose employers do not offer the benefit will also be able to join this program through a government payment mechanism.

Individuals qualify to receive benefits when they need help with certain activities of daily living and they have paid premiums for at least 5 years and have worked for at least 3 of those 5 years. Beneficiaries receive lifetime cash benefits based on the degree of impairment, expected to average roughly $75 a day or roughly $27,000 a year. Benefits can be used to maintain independence at home or in the community and should be sufficient to cover typical costs of home care services or adult daycare. Benefits can also be used to offset the cost of assisted living and nursing home care.

Let me tell you how the improved version of this act protects the taxpayer. There have been issues raised about how they are going to be protected under this program. All CLASS Act benefits are paid by voluntary participants, not taxpayers. The CLASS Act actually would save taxpayer dollars by reducing Medicaid costs—according to CBO, almost $2 billion. CLASS Act premiums must be set at a level sufficient to guarantee actuarial soundness of the program.

We thank Senator GREGG for his amendment in the debate on the CLASS Act bill when it came up in committee.

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

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

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

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

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

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

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

As the Congressional Budget Office discusses, the CLASS Act would function just like any other private long-term care insurance program which finances benefit payments from a premium reserve and interest income off that reserve. Due to budget scorekeeping, the CBO finds that premium revenue exceeds benefit payments in the third decade but does not take into consideration accumulated reserves and income off those reserves that keep the program fiscally independent.

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

Of course, what we don't calculate here, because I don't know how one would calculate it, is that notion of independence. I suspect maybe all of us

know people who are on Medicaid and know the frustration particularly of someone who is otherwise healthy but suffers from disabilities who would like to work and wants to keep independent. Yet if you go into the Medicaid Program, there are huge restraints on your ability to do so. So by this program, aside from financially reducing Medicaid costs, we are actually providing that additional sense of human dignity and decency that just because you have a disability and you need help doesn't mean you don't want to be self-sufficient and keep working. There is the gratification of knowing you are contributing in some way other than being shuttered away, having impoverished yourself, relying on others' assets to take care of you because you do not have those resources.

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

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

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

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

All of those facts I cannot put a dollar amount on. I cannot tell you what the financial benefit is of someone getting up in the morning, getting a little help but going off to a job and knowing they are needed and have worth and value as a human being. What is the dollar amount on that? I cannot tell you, except I know it has value in our country. Or the alternative? Getting rid of all your assets, impoverishing yourself, relying on your family or friends to take care of you in order to try to survive, when you could be doing more.

So I hope my colleagues will support the Whitehouse amendment when it is offered to strengthen this program and that they will resoundingly defeat the effort to cut this program out of the bill altogether. I cannot think of a worse thing we could do with a piece of legislation that is designed to be creative, innovative, reduce costs, and make a difference for millions of our fellow citizens. And a growing number—as was pointed out, by the year 2030, 14 million Americans in our country, and I suspect more—will be in need of services such as these.

I see my colleague and friend from Iowa on the floor, who has been as strong a champion as this Congress has ever had when it comes to the disabled in our country, having been the author of the Americans with Disabilities Act, along with others but nonetheless the principal architect of that effort, and he can speak more eloquently than any other human being I have ever known about why this program is important and what it means.

Mr. President, I ask unanimous consent that the list of 275 organizations that strongly endorse and support Senator Kennedy's CLASS Act be printed in the RECORD.

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

HEALTH CARE REFORM/CLASS ACT OF 2009
NATIONAL SUPPORT LIST

DISABILITY GROUPS

ADAPT, America Psychological Association, American Association on Health and Disability, American Association on Intellectual and Developmental Disabilities, American Association of People with Disabilities, American Association on Mental Retardation, American Congress of Community Supports and Employment Services, American Foundation for the Blind, American Medical Rehabilitation Providers Association (AMRPA), American Music Therapy Association, American Physical Therapy Association, American Network of Community Options and Resources, Anxiety Disorders Association of America, The ALS Association, Assisted Living Federation of America, Association of Assistive Technology Act Programs, Association of Programs for Rural Independent Living, Association of University Centers of Disabilities, Autism Society, ACCSES.

Bazelon Center for Mental Health Law, Brain Injury Association of America, Center for Disability Issues and the Health Professions at Western University of Health Sciences, CSAVR (Council of State Administrators of Vocational Rehabilitation), Consortium of Citizens with Disabilities (umbrella organization for 114 advocacy groups), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), Council for Learning Disabilities, Center for Accessible Living, Depression and Bipolar Support Alliance, Disability Policy Collaboration, Disability Rights Education and Defense Fund, Easter Seals, Epilepsy Foundation, Higher Education Consortium for Special Education Teacher Education, Helen Keller National Center, Division of the Council for Exceptional Children, Justice for All, Mental Health America, National Academy of Elder Law Attorneys, National Alliance on Mental Illness, National Association for Anorexia Nervosa and Associated Eating Disorders.

National Association of Councils on Developmental Disabilities, National Association of County Behavioral Health and Developmental Disability Directors, National Association of State Directors of Developmental Disabilities Services, National Association of State Head Injury Administrators, National Center on Learning Disabilities, National Coalition on Deaf-Blindness, National Council on Independent Living, National Disability Rights Network, National Down Syndrome Society, National Down Syndrome Congress, National Multiple Sclerosis Society, National Organization on Disability, National PACE Association, National Rehabilitation Association, National Spinal Cord Injury Association, Paralyzed Veterans of America, Rehabilitation Engineering and Assistive Technology Society of North America, Research Institute for Independent Living, Self-Advocates Becoming Empowered, Special Olympics, Inc.

TASH, The Arc of the United States, The Autistic Self Advocacy Network, Tourette Syndrome Association, United Cerebral Palsy, United Spinal Association, US Psychiatric Rehabilitation Association.

AGING GROUPS

AARP, Alliance for Retired Americans, Alliance for Quality Long Term Care, Alzheimer's Association, Alzheimer's Foundation of America, American Association for Geriatric Psychiatry, American Association for Homecare, American Association for Homes and Services for the Aging, American Health Care Association, Association of BellTel Retirees, Association of Retired Americans, ATAP (Assistive Technology Programs), Burton Blatt Institute, National Alliance for Caregivers, National Association for Homecare and Hospice, National Association of Area Agencies on Aging, National Association of Nutrition and Aging Services Programs, National Association of Professional Geriatric Care Managers, National Association of State Units on Aging, National Council on Aging, National Family Care Givers Association.

National Indian Council on Aging, National Respite Coalition, Notre Dame du Lac Assisted Living, OWL—The Voice of Midlife and Older Women, Prima Council on Aging, ProtectSeniors.org, The National Consumer Voice for Quality Long-Term, The National Voice for Quality Long-Term Care, Therapeutic Communities of America, United Neighborhood Centers of America, Volunteers of America, Wider Opportunities for Women.

HEALTHCARE GROUPS

American Academy of Pediatrics (AAP), Ambulatory Behavioral Healthcare, American Association for Marriage and Family Therapy, American Congress of Rehabilitative Medicine, American Counseling Association, American Diabetes Association, American Group Psychotherapy Association,

American Hospital Association (AHA), American Mental Health Counselors Association, American Occupational Therapy Association, American Society on Consultant Pharmacists, American Therapeutic Recreation Association, Association for Ambulatory Behavioral Healthcare, Assoc. of the Advancement of Psychology, Bazelon Center for Mental Health Law, Center for Medicare Advocacy, Families USA, Family Voices, Gay Men of African Descent, Medicare Rights Center.

Mujeres Unidas Contra el SIDA, National Alliance to End Homelessness, National Partnership for Women and Families, National Association of Children's Behavioral Health, National Association of Mental Health Planning Councils, National Association of School Psychologists, National Coalition of Mental Health Consumer/Survivor Organizations, National Committee to Preserve Social Security and Medicare, National Council for Community Behavioral Health Care, National Foundation for Mental Health, National Health Council, National Minority AIDS Council, The Center for Medical Advocacy, Visiting Nurses Association of America.

UNIONS

American Federation of Labor-Congress of Industrial Organizations (AFL–CIO), American Federation of State, Country, and Municipal Employees (AFSCME), Service Employees International Union (SEIU), American Federation of Teachers (AFT), National Association of Active and Retired Federal Employees (NARFE).

RELIGIOUS ORGANIZATIONS

American Association of Pastoral Counselors, American Baptist Home Mission Societies, Association of Jewish Aging Services of North America, Association of Jewish Family and Children's Agencies, B'nai B'rith International, Catholic Health Association of the United States, Council of Health and Human Service Ministries of the United Church of Christ, Episcopal Community Services in America, Evangelical Lutheran Good Samaritan Society, Evangelical Lutheran Church in America, Friends Committee on National Legislation, Hindu American Foundation, Islamic Society of North America, Jewish Council for Public Affairs, Lutheran Services in America, L'Arche USA, Mary Immaculate Health/Care Services, Masonic Communities and Services Association, National Council of Jewish Women, Presbyterian Church (U.S.A.).

Presbyterian Association of Homes and Services for the Aging, Sisters of Charity, United Jewish Communities, The Jewish Federations of North America, The Union for Reform Judaism, Unitarian Universalist Association of Congregations, United Methodist Church.

HIV/AIDS ORGANIZATIONS

ActionAIDS, Philadelphia, PA; African Services Committee, New York, NY; AIDS Action Baltimore, Baltimore, MD; AIDS Action Council, Washington, DC; AIDS Action Committee of Massachusetts, Boston, MA; AIDS Alabama, Birmingham, AL; AIDS Alliance for Children, Youth & Families, Washington, DC; AIDS Coalition of Southern New Jersey, Bellmawr, NJ; AIDS Foundation of Chicago, Chicago, IL; AIDS Housing Alliance/SF, San Francisco, CA; AIDS Law Project of Pennsylvania, Philadelphia, PA; AIDS Legal Council of Chicago, Chicago, IL; AIDS Legal Referral Panel, San Francisco, CA; AIDS Partnership Michigan, Detroit, MI; AIDS Project Los Angeles, Los Angeles, CA; AIDS Services Foundation Orange County, Irvine, CA; AIDS Task Force, Wheeling, WV; AIDS Treatment Data Network, New York, NY; AIDSNET, Bethlehem, PA; American Dental Education Association, Washington, DC.

Asian & Pacific Islander Wellness Center, San Francisco, CA; Association of Nurses in AIDS Care, Akron, OH; Association of Nutrition Services Agencies (ANSA), Washington, DC; Better Existence with HIV (BEHIV), Chicago, IL; Black Coalition on AIDS, San Francisco, CA; CAEAR Foundation, Washington, DC; Catholic Charities CYO, San Francisco, CA; Colorado AIDS Project, Denver, CO; Center on Halsted, Chicago, IL; The COLOURS Organization, Inc., Philadelphia, PA; Common Ground—the Westside HIV Community Center, Santa Monica, CA; Community Care Management Corporation, Ukiah, CA; Community Healthcare Network, New York, NY; Community HIV/AIDS Mobilization Project (CHAMP), New York, NY & Providence, RI; Community Research Initiative of New England (CRI), Boston, MA; Face to Face/Sonoma County AIDS Network, Santa Rosa, CA; Fenway Community Health, Boston, MA; Gay Men's Health Crisis (GMHC), New York, NY; Harlem United Community AIDS Center, New York, NY; Hawaii Island HIV/AIDS Foundation, Keaau & Kailua-Kona, HI; Health and Home Support Services, Inc., Newport News, VA.

Health Imperatives, Brockton, MA; HIV ACCESS, Alameda County, CA; HIV/AIDS Services for African Americans in Alaska, Anchorage, AK; HIV/AIDS Services/Greater Love Tabernacle Church, Dorchester, MA; HIV Dental Alliance, Atlanta, GA; HIV Health and Human Services Planning Council of New York, New York, NY; HIV Health Services Planning Council, Sacramento, CA; HIV Health Services Planning Council—San Francisco EMA, San Francisco, CA; HIVictorious, Inc., Madison, WI; HIV Medicine Association, Arlington, VA; Housing Works, New York, NY; Hyacinth AIDS Foundation, New Brunswick, NJ; Inova Juniper Program, Springfield, VA; JRI Health/Sidney Borum Health Center, Boston, MA; Lansing Area AIDS Network, Lansing, MI; L.A. Gay & Lesbian Center, Los Angeles, CA; Legacy Community Health Services, Inc., Houston, TX; LifeLinc, Baltimore, MD; Lifelong AIDS Alliance, Seattle, WA.

Lower East Side Harm Reduction Center, New York, NY; Michigan Positive Action Coalition (MI-POZ), Detroit, MI; Minnesota AIDS Project, Minneapolis, MN; Nashville CARES, Nashville, TN; National Alliance of State and Territorial AIDS Directors, Washington, DC; National Association of AIDS Education and Training Centers, Detroit, MI; National Association of People with AIDS, Washington, DC; The National Coalition for LGBT Health, Washington, DC; National Minority AIDS Council, Washington, DC; National Pediatric AIDS Network, Boulder, CO; National Women and AIDS Collective, Brooklyn, NY; New York City Health and Hospitals Corporation, New York, NY; NYC AIDS Housing Network (NYCAHN), New York, NY; The New York State Nurses Association, Latham, NY; New York State Wide Senior Action Council, Inc., Albany, NY; Okaloosa AIDS Support and Informational Services, Inc. (OASIS), Ft. Walton Beach, FL; Open Arms of Minnesota, Minneapolis, MN; Partnership Project, Portland, OR; Paterson Counseling Center, Inc., Paterson, NJ; People Living With HIV/AIDS Committee of the Baltimore Planning Council, Baltimore, MD.

Positive East Tennesseans, Knoxville, TN; Project Open Hand, San Francisco, CA; Project Inform, San Francisco, CA; Ryan White Medical Providers Coalition, Arlington, VA; San Francisco AIDS Foundation, San Francisco, CA; Sisters Together And Reaching, Inc. (STAR), Baltimore, MD; Southern NH HIV/AIDS Task Force, Nashua, NH; Strong Consulting, Crescent City, CA; Test Positive Aware Network, Chicago, IL; The AIDS Institute, Washington, DC & Tampa, FL; The Albany Damien Center, Albany, NY; The International Community of Women Living with HIV/AIDS (ICW), Washington, DC; The Sexuality Information and Education Council of the United States (SIECUS), Washington, DC; Treatment Action Group (TAG), New York, NY; Triad Health Project, Greensboro, NC; United Methodist Mexican-American Ministries, Garden City, KS; Victory Programs, Inc., Boston, MA; Village Care of New York, New York, NY; Wilson Resource Center (WRC), Arnolds Park, IA; Women Together for Change, St. Croix, U.S. Virgin Islands.

Mr. DODD. I yield the floor.

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

Mr. HARKIN. Mr. President, I wish to thank our friend and leader on this issue, Senator DODD, for his eloquence in supporting what so many of our elderly in this country want more desperately than just about anything else; that is, the peace of mind of knowing that if they should become disabled, they will not be forced to go into a nursing home, they will have some support, and they will be able to live in their homes in their communities. Talk to anyone with a disability—not just the elderly, anyone with a disability—and they will tell you how important it is that you have that kind of assurance that if, God forbid, you become disabled, your only hope will not be to go into a nursing home for the rest of your natural life.

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

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

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

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

I offered an amendment, which was ultimately accepted, that would require that

CLASS Act premiums be based on a 75-year actuarial analysis of the program's costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really, passing the debt—to future generations. I'm pleased the HELP Committee unanimously accepted this amendment.

The CBO has scored this. This is completely paid for over 75 years—over 75 years. I do not understand why anyone would want to strike it.

What Senator WHITEHOUSE has said—again, I think this is very appropriate for us—is that any savings we get from this be reinvested either in the CLASS Act—so when people do get disabled, maybe they will get a little bit more money. So we have some savings in the CLASS Act. What Senator WHITEHOUSE has said is, put those savings back in the CLASS Act or Social Security. It makes sense to me. So again, I think it is an improvement on the bill, what Senator WHITEHOUSE is suggesting.

I plead—I plead—with my fellow Senators, do not kill this program aborning. We stood here on this floor 19 years ago, on July 20, 1990. We stood on this floor to pass the Americans with Disabilities Act. There were a few votes against it. In fact, there are one or two people still here who voted against it. I think if you asked them now, they would say it has been a pretty darn good bill. It has broken down a lot of barriers, opened a lot of doors for people with disabilities in our country, changed our environment in this country, not only in terms of physical access, but I think, more importantly, it has changed how we view people with disabilities, no longer looking at people with a disability to say, what is their disability, we now look at those people and say, what are your abilities, what can you do—not just looking at someone's disability. So we have come a long way.

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

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

So I hope we will support the Whitehouse amendment and make sure this fund is totally solvent. I think he is on the right track, that if there are savings, to put the money back in there, so maybe that $75 a day could be maybe $80 a day, or something like that, to help people.

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

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

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

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

AARP STATEMENT ON THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS PROGRAM

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

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

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

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

I have a nephew, Kelly; my sister's boy. He got injured at a very young age; he was only 19 years old. It made him a severe paraplegic, almost a quadriplegic. My sister and her husband did not have any money at all. Yet Kelly was able to go to college—go to school. He was able to get a job, able to live in a house by himself. He had his own little home. He had his own van he drove that had a lift on it, and he could get his wheelchair in there and drive it to work. He actually started a small business and employed some people. He has lived a full life. He is now a man of about 50. He has had a great life. Even with that disability, he has been able to get around and do things. He is a taxpayer. He has paid taxes. He has employed people. Every night when he goes home, he has to have a nurse come in the home and get him ready for bed and for him to do his exercises and things such as that. Then, in the morning, he has to have another nurse to get him out of bed and take care of his needs, get him ready to go. Actually, Kelly gets his own meals and stuff. Then he goes off to work and comes back. This happens every day.

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

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

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

I thank the President and I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

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

The PRESIDING OFFICER. The Republican deputy leader.

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

Mr. DODD. Forty minutes, equally divided.

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

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

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona is recognized.

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

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

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

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

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

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

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

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

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

Former Senator Clinton from New York, for example, said that these Medicare+Choice plans—that is now what we call the Medicare Advantage plans, and I am quoting:

> . . . are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. While we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today.

The current senior Senator from Massachusetts said at the time, and I quote:

> I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice program for seniors. This should be among our highest priorities in this year's Medicare debate.

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

So why has this all of a sudden become unpopular with our friends on the other side of the aisle? Well, obviously, first and foremost, they need trillions of dollars to fund their bill, so they look around for where they can get some money and decide: Well, we can get $120 billion from here; this is one way we can help pay for the new entitlements under their bill. But to them, there has to be some kind of justification to take that money, so the idea is: Well, it is not fair that the government would pay money into this program for extra benefits for seniors when that money could be spent on regular fee-for-service Medicare. Of course, that argument presupposes that government health care is always superior to the plans offered in the private market, which these seniors have made clear, by doubling the enrollment in the private plans, is not the case. As I said, they have made their preference clear.

They asked us for choices, as Members of Congress enjoy. They want access to private plans and these additional benefits, and we delivered as promised. We gave them the choices, Republicans and Democrats alike. Now they need the money, so they decide this is a way to get some money to pay for their new entitlement.

Our friends on the other side of the aisle have been talking about overpayments. There is no such thing as an overpayment in this program under the law. No money goes to the plans. It is not as if the insurance companies get the money from the government. The insurance companies, if their bid is under what the traditional Medicare bid is, have to return 25 percent of it to the U.S. Government and the other 75 percent, by law, must go to their beneficiaries, either in the form of lower premiums or additional benefits. So these aren't overpayments to the plans, as has been represented. As I said, 75 percent of the additional payments must be used to provide seniors with extra benefits, which could include lowering premiums, including chronic care management, and so on. The other 25 percent is returned to the government, so there is no overpayment.

Some on the other side argue that they are protecting guaranteed benefits. Well, this is semantics. Nobody is going after the benefits Medicare has traditionally supplied. What we are pointing out and what this amendment would prevent from happening is, the benefits under Medicare Advantage would not be cut, and there is no question—nobody can deny—that those benefits would be cut. In fact, according to the CBO, by the year 2019, they will have been cut by 64 percent, a huge—almost $90—over $90 in actuarial value. So my point is, seniors, of course, would like to keep what they have.

What about this promise if you like what you have, you get to keep it. Sorry. Not if you are on Medicare Advantage. As I said, according to the Congressional Budget Office, the legislation would cut benefits from $135 a month actuarial value to $49 actuarial

value. That is a real cut. It may not sound like much to some people, but to our seniors, it is a huge hit. They are asking what happened to this promise to let them keep what they have.

There is an interesting memo by James Capretta and Robert Book, who write for the Heritage Foundation, on the Medicare Advantage cuts, and here is what they say:

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

That is what the Hatch motion is attempting to prevent, to preserve these benefits for seniors.

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

One constituent from Phoenix says:

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

We are trying.

A constituent from Peoria, AZ, says:

I oppose cuts to Medicare Advantage. I have two family members receiving health care under this program. The care has consistently been outstanding due to the efforts of our case manager in coordinating patient care between providers and patients. We have a voice in determining type and scope of our care. Please do not cut Medicare Advantage!

Here is a note from a constituent from Apache Junction:

I have heard reports that if passed, the new government health care plan would do away with or cut Medicare Advantage. If so, it would nearly double my health care costs with my present health care provider. I do not want any legislation passed that would take away the Medicare Advantage option for seniors.

Another constituent from Peoria:

President Obama has said we can keep the insurance we have if we like it, but has said he wants to cut or eliminate Medicare Advantage. What happens to the millions of people who have Medicare Advantage? These are all seniors, many of whom cannot afford to pay more. Why should so many seniors have to sacrifice in order to help pay for universal coverage? Why do we not hear more debate on this issue?

Well, to my constituent from Peoria, that is what this debate is all about. We are trying to prevent these cuts.

Here is a constituent from Prescott Valley:

I have Medicare Advantage. My husband wants to retire from his job where he has excellent health coverage for some serious health concerns. So long as he has good medical coverage, he does well. Should Medicare Advantage be cut, his health would necessarily suffer after his retirement. We cannot afford higher supplemental coverage. I don't want to lose my husband. I have spent many a sleepless night wondering how to keep my husband healthy once he retires. I have several friends currently undergoing chemotherapy and they are wondering if their health would be in jeopardy if Medicare Advantage were cut. Are we not worth saving? Clearly, there are many who want to spend our money on their own priorities. God bless you, sir, for advocating on our behalf!

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

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

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

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

My bottom line in supporting the Hatch amendment is that we should not punish seniors who signed up to have the choice of Medicare Advantage. There are better ways to reform health care. We have talked about those ways. Our senior citizens have paid into the program. They have asked us for this program. Democrats and Republicans have supported it in the past. Now, simply because somehow or other we have to scrape up money for the new entitlements in this legislation, we are going to attack the very program all of us have supported in the past.

It is unfair, it is not right, and we need to defeat those cuts in Medicare, and that is why the Hatch motion to preserve Medicare Advantage should be supported by my colleagues.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

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

For instance, I will read from the letter:

For nearly 5 million Medicare beneficiaries across America, Medicare Plus Choice—

That is what it was called before Medicare Advantage—

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

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

Et cetera, et cetera. We have plenty of history in the Senate that is bipartisan that we ought to maintain—Medicare Advantage—rather than do an injustice to it, as this legislation before the Senate is trying to do.

I ask unanimous consent to have this letter printed in the RECORD.

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

U.S. SENATE,
Washington, DC, September 30, 2003.

DEAR MEDICARE CONFEREE: We are writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding in fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope that the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the ''Medicare+Choice Equity and Access Act.''

Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice programs. Although the Senate version of the Medicare bill does include a modest increase in reimbursement rates in FY 2005, we were pleased to see that the House version contains a more comprehensive commitment to strengthening Medicare+Choice beginning in 2004.

Medicare+Choice uses private sector innovations to offer all of the traditional Medicare benefits in addition to extra benefits such as prescription drug coverage, vision benefits, and hearing aids. These added services are particularly important to low-income seniors who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. In many cases, this program is the only option for low-income seniors to receive comprehensive, affordable health coverage.

But in recent years, lack of adequate government funding for the Medicare+Choice program has steadily reduced the health plan choices and benefits of seniors across the nation. As funding increases have continually fallen short of rising health care costs, seniors have watched the quality of their health

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

We strongly support additional Medicare+Choice funding for two very important reasons: (1) to protect the health care choices and benefits of the nearly 5 million Medicare beneficiaries who are currently enrolled in private sector health plans; and (2) to strengthen the foundation for future health plan choices.

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

Sincerely,

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

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

Mr. BARRASSO. Yes.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

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

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

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

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

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

We hear a lot about the failings of the health care system, and there are many in this country, and one of them is that care is not coordinated. People go from specialist to specialist. We need coordinated care. Medicare Advantage does a much better job at coordinating care than traditional Medicare.

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

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from Wisconsin.

The PRESIDING OFFICER. The Senator from Wisconsin is recognized.

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

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

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

And thanks to amendments accepted in the Senate Health, Education, Labor, and Pensions Committee, the bill language is stronger than ever. Senator GREGG, my colleague on the Budget Committee, amended the bill to require the Secretary of Health and Human Services to set premiums that are actuarially sound for a 75-year window, and maintain sustainable enrollment and benefit structure. While some have suggested that the CLASS Act is fiscally not sound, the Gregg amendment should put those concerns to rest.

Long-term care reform has been a cornerstone of my work in public office since my days in the Wisconsin State Senate. I have seen how important it is to give people options so that they can match the level of care and assistance to their personal needs. Pushing anyone and everyone into Medicaid, or into a nursing home, is a waste of potential, a waste of opportunity, and a waste of money. Medicaid and our Nation's nursing homes have a critical role to play for some Americans. But for many Americans, it is simply not the right fit. The CLASS Act will ensure that taxpayer dollars are spent enrolling only those who truly need Medicaid into the program, and help others save for a time when they might need some assistance to remain independent. The CLASS Act is a critical part of this health reform bill, and I urge my colleagues to oppose any effort to weaken or strike this program from the bill.

I yield the floor.

Mr. DODD. Mr. President, the Senator from Rhode Island wants to be heard.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. Mr. President, I will speak for just a moment because I know the Senator from Pennsylvania wishes to speak. When he comes to the floor, I will quickly yield to him. While there is a moment in between, I want

to speak to some of the arguments we have heard.

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

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

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

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

I know the Senator from Connecticut wishes to use an example. I will yield to him on his signal. We have seen this before. We saw this not long ago on the public option, which would compete with insurers head to head on a fair and level playing field. It was completely voluntary, and it had to be actuarially self-sustaining. It had to meet the solvency laws of the State in which it operated. In both cases, our colleagues on the other side have rushed to the floor to talk about deficits and how these will contribute to the deficit.

These are both actuarially self-sustaining programs required to stay solvent. Yet here they come to raise the specter of deficits. But this is the same party that pays for 14-percent subsidies to private insurers to compete with Medicare. As my son would say, duh, if you are getting 14 percent extra, it is pretty easy to compete.

When they asked for that deal, they promised they would drive costs down. In fact, they have driven costs up, and they put it in their pockets. It is not fair to the insurers that are not in the program. It is greedy on their part. All we want to do is hold them to their promises.

Do we hear any concerns about the deficit problem on the 14-percent subsidy for the Medicare Advantage Program? No, dead silence—guess what—because it helps the insurance industry.

When the Part D program came in, our friends on the other side forced through a provision—a unique provision—that gave the pharmaceutical industry a special privilege that the U.S. Government could not negotiate with it over price—could not negotiate with it. Lord knows how much that has added to our deficit. But have they ever come to complain? No, because the beneficiary is the pharmaceutical industry. But when things help regular people, when things help competition in the insurance market, even where they are required to be actuarially self-sustaining and solvent, then suddenly they turn up. They can detect the threat of deficit in parts per billion when it helps somebody. But a patent, actual living, breathing, deficit-enhancing subsidy that is on the books right now, they don't care about if it helps the pharmaceutical industry or the insurance industry.

As we have this discussion, that is a point worth bearing in mind because it is not just the substance of the amendment, it is the credibility of the argument that counts.

I said I would yield to the distinguished Senator from Pennsylvania when he arrived, and he has arrived. Without further ado, I yield the floor.

Mr. CASEY. Mr. President, I thank my colleague from Rhode Island, Senator WHITEHOUSE, who has been among the more forthright and capable advocates of what we are talking about today, not only with regard to health care generally, but in particular what brings us to the floor at this moment, among several issues, but principally his work and the work over many years that Senator Kennedy did for the so-called CLASS Act, the Community Living Assistance Services and Supports Act.

What is this all about? I wish to talk for a couple of minutes about how it works. I think sometimes we get lost in the discussion about the finer points of a policy or program and we tend to forget what it means. Here is what it means. Here is what it means for an American who is working and wants to continue working to support his or her family or to support themselves, contribute to our economy, demonstrate that people who happen to live with a disability of one kind or another can be so significant in our economy, can contribute so much with their ability and their brain power and their ability to contribute in a very positive way.

We are talking about the dignity of work, whether the Senate is going to stand up and say: With this act, with this program for someone who happens to have a disability and wants to work and wants to voluntarily contribute premiums so they have some security, some peace of mind down the road if they should need this help, we are talking about the dignity of that work.

This is a test of the Senate, whether we are going to stand up for people who have a disability and their opportunity to work. It is a very simple question. You either stand with them or you do not.

It is also about one important word, I think—independence, whether we are going to say to someone who wants to work and has a disability, are they going to have the independence, the freedom to work and live the life they choose?

Here is how it works. This is not complicated. This is not some mysterious program. Here is how it works. Here is how they qualify to get these benefits. They qualify to receive benefits when they do three things. First, they need help with certain activities of daily living. We all know what those are. There are so many people out there who can work and can contribute if we give them a little help, just a little bit of help that we are talking about today to do the basic things in life—to be able to wake up in the morning and, if you have a disability, maybe have someone help you get ready for work, whether that is getting in the shower, shaving, whatever you have to do to get ready for work in the morning—activities of daily living, things that people who do not have disabilities take for granted. That is the first thing you have to have is that need that we can all understand.

Secondly, this person would have to pay premiums for at least 5 years before they could benefit from the program. I said ''premiums.'' I did not say a ''government subsidy.'' We are talking about premiums here, and this is a program that certainly has its origin in government, but this is not exactly similar to the Children's Health Insurance Program, for example, or Medicaid, where it is a government program that helps a particular person, a person who happens to have a disability or is a child. In this case, people are paying premiums, and they have to pay those premiums for 5 years.

In addition to the need and paying premiums, the third requirement is they have to work at least 3 of those 5 years. We are talking about people who are employed, working people who happen to have a disability. This is a creative program to help them do that.

Why do we get the opposition we do from across the aisle? I think it is pretty simple. We have a lot of folks across the aisle who want to kill this bill. So they are going to try to strike the CLASS Act, which is outrageous and insulting. They are going to try to strike whatever they can, if they can, to kill the bill. So this is a bill-killing exercise. This is not a debate about the finer points of the CLASS Act. This is a bill-killer exercise. It is very simple, and I think it will tell a lot about where people stand.

Let me go into a couple more details. I know we are almost out of time. Here is what happens to that beneficiary—a person working, a person who has a need, and a person who has paid premiums. That beneficiary receives a lifetime cash benefit based on the degree of impairment, not just any old formula. We want to make sure the benefit corresponds to someone's impairment, their inability to do their job or live their life the way they hope

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

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

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

It makes a lot of sense. It is solvent, and it will help those who have a disability who want to work, who want to go to work every day and live a full life.

Mr. President, I yield the floor.

Mr. DODD. Mr. President, I yield whatever time we may have remaining to Senator KIRK of Massachusetts, who has done an incredible job in very difficult circumstances—replacing our beloved former colleague Ted Kennedy from Massachusetts. He has been a valuable contribution over these days he has been here. I know he wishes to say a few words as well.

The PRESIDING OFFICER. The Senator from Massachusetts.

There is 3 minutes remaining.

Mr. KIRK. Mr. President, I thank Senator DODD and Senator BAUCUS for their tireless leadership on this entire health care bill.

I wish to say a word about the CLASS Act. We have heard Senator DODD and others say this is the core element of this health reform bill championed by Senator Edward Kennedy. I say if he were here today, he would say this is not about politics; this is about the content of the character of our Nation. He believed, as I do, and I know Senator DODD does, this Nation is judged or should be judged on how we treat the infirm and the weakest among us. This CLASS Act, as was eloquently pointed out by Senator CASEY of Pennsylvania, involves no taxpayer funds, is fiscally solvent, and does what everyone says we must do: provide independence, self-respect, and dignity to the infirm in our society.

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

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

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

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

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

I yield the floor.

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

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

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

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

A Senator WHITEHOUSE amendment re: Social Security fiscal responsibility; the Republican leader's designee amendment re: fiscal responsibility; Senator STABENOW's side-by-side amendment re: Medicare Advantage; and Senator HATCH's motion to commit re: Medicare Advantage.

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

The PRESIDING OFFICER. Is there objection?

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

The PRESIDING OFFICER. The majority leader.

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

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

Mr. REID. In the afternoon. I think we will need some debate in the morning.

Then Sunday morning, at the request of the Republican leader, we are not going to come in until noon, or thereabouts.

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

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

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

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

The PRESIDING OFFICER. Is there objection to the request?

Hearing no objection, it is so ordered.

The Senator from South Dakota.

AMENDMENT NO. 2901 TO AMENDMENT NO. 2786

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

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

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

The amendment is as follows:

(Purpose: To eliminate new entitlement programs and limit the government control over the health care of American families)

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

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

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

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

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

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

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

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

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

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

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

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

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

Sincerely,

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

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

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

The letter goes on to say:

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

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

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

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

The fact is, the chairman of the Senate Budget Committee, Senator CONRAD, has described this as a Ponzi scheme of the first order—something that Bernie Madoff would be proud of.

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

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

They say, well, it is actuarially solvent over 75 years. Well, maybe, because you are running surpluses in the early years. But in the later years, you are running huge deficits. In the early years the surpluses are being spent. They are not being put into paying benefits for this program, when those benefits start being demanded by the people who have participated in the program.

Just look at what others have said about this program, Mr. President. I have quoted for you what the chairman of the Budget Committee, Senator CONRAD, said with regard to this program; that it is a Ponzi scheme of the first order, and that is being echoed by others. But this is what the administration's chief health actuary said about the CLASS Act. He said it would result ''in a net Federal cost in the longer term.'' The chief actuary also determined the program faces ''a significant risk of failure'' because the high cost will attract sicker people and lead to low participation.

The Congressional Budget Office agreed, saying:

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

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

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

Even the Washington Post recognizes this for what it is. It is a sham. This is a budget gimmick, Mr. President, that is designed to obscure the cost of this program by generating surpluses in the early years. It is supposed to generate $72 billion in the first 10-year window, so that counts on the balance sheet of health care reform to make it look better. But this program is going to run deficits—deficits as far the eye can see—once the chickens come home to roost. Who will pay the bill for that? Future generations of Americans.

Mr. President, this is not good policy. Certainly, if you look at programs we already have on the books, Medicare is destined to be bankrupt in the year 2017. We have big problems down the road—unfunded liabilities in Social Security. This would create a huge new liability down the road that would be unfunded because all the money that comes in during the early years is going to be spent. This is more of the same old business as usual in Washington, DC, that the American people are fed up with. We can make people happy today by saying we are creating this new program that makes the majority's health care reform bill look better because it obscures the real cost of this bill by rolling in these revenues in the early years. But there is a long-term impact, according to the CBO, according to the actuary at Health and Human Services, and according to a lot of our colleagues on the other side—the seven Democrats who signed the letter, including the chairman of the Budget Committee, who, as I said, has called this program a Ponzi scheme of the first order; something that would make Bernie Madoff proud.

I don't know how my colleagues on the other side, with a straight face, can come to the Senate floor and say this is a great program, that it is actuarially sound. Sure, it may be a benefit to a few people, but I have to tell you, somewhere down the road, when the chickens come home to roost, there is going to be a huge liability that is going to be facing future taxpayers, future generations of Americans, as we start to pile up more deficits and more debt as a result of this Ponzi scheme.

This is a sham, Mr. President. I hope my colleagues will support this amendment. It would strike the CLASS Act from the underlying bill, not allow those revenues to be assumed in paying for or understating the cost of this bill, and not pile mountains of debt onto future generations.

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

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

One of the oft-repeated arguments we have heard in favor of the CLASS act is that it would reduce budget deficits between 2010–2019.

First, when has a government program ever reduced budget deficits?

Second, the Congressional Budget Office tells us that this program will actually add to future Federal budget deficits. The CBO writes: ''The program would add to future federal budget deficits in large and growing fashion.''

Why would it do this?

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

As the CBO tells us, the program would ''lead to net outlays when benefits exceed premiums.'' (By the third decade of program operation—2030–2039—CBO assumes that CLASS begins to generate net increases in Federal outlays. The net increase in Federal outlays is estimated to be ''on the order of tens of billions of dollars for each (succeeding) ten-year period.''

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

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

Bottom line, this program is not sustainable outside the 10-year window.

That is why the Washington Post called it, ''a gimmick . . . designed to pretend that healthcare is fully paid for.''

The Post goes on:

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

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

The PRESIDING OFFICER. There is 19 minutes remaining; on the Republican side, 10½.

Mr. DODD. Mr. President, I see my colleague from Minnesota. Does he wish to be heard? How much time does my colleague need?

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

Mr. DODD. Take 4.

Mr. FRANKEN. I will use it.

The PRESIDING OFFICER. The Senator from Minnesota.

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

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

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

The public option will offer affordable premiums and a comprehensive benefits package for Americans struggling with their health care costs. It is going to provide the kind of coverage Americans need to be healthy. The public option will foster competition among private health insurance companies and lower long-term costs for Minnesotans and for families all across the country. There is no cost for the public option to the Treasury. In fact, CBO estimates it saves $3 billion. It is a win-win situation.

It is important to remember that a public option doesn't mean private health insurance goes away. In fact, after health reform, 188 million Americans will have coverage through a private insurer. Only 2 percent of the overall insured population is projected to enroll in the public option. This is just another option you will have. It is an option because that is what the bill is about.

Mr. BROWN. Will the Senator from Minnesota yield?

Mr. FRANKEN. Absolutely.

Mr. BROWN. I know my colleague joined with Senator DODD, Senator MIKULSKI, and me to push this amendment that Members of the House and Senate actually go on the public option, partly to show we believe in it. It is a little curious that two of the sponsors, at least, Senator COBURN and Senator VITTER and some others, are so much against the public option that they want to pass this amendment. It sounds to me as if the Senator is serious about going on it, as I am, correct?

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

The PRESIDING OFFICER (Mr. REED). The Senator from Minnesota has consumed 4 minutes allotted by the Senator from Connecticut.

Who yields time?

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

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

The Senator from Utah is recognized.

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

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

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

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

That is the predecessor to Medicaid Advantage—

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

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice [the predecessor] is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the ''Medicare+Choice Equity and Access Act.''

That became Medicare Advantage.

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

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

By the way, let me just mention the Democrats who signed this letter, who wanted Medicare Advantage: JOHN KERRY, ARLEN SPECTER, DIANNE FEINSTEIN, JOE LIEBERMAN, PATTY MURRAY, CHARLES SCHUMER, FRANK LAUTENBERG, Hillary Rodham Clinton, RON WYDEN, Mark Dayton, MARY LANDRIEU, MARIA CANTWELL, and CHRISTOPHER DODD. Fourteen Democrats signed this letter, along with a number of bipartisan Republicans, who believed we really needed to include Medicare Advantage.

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

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

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

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

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

Mr. HATCH. I ask for another 2 minutes.

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

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

Mr. DODD. The Senator has 4 minutes.

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

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

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

The PRESIDING OFFICER. Who yields time?

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

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

AMENDMENT NO. 2899 TO AMENDMENT NO. 2786

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

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

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

Ms. STABENOW. I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows.

(Purpose: To ensure that there is no reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans)

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

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

Ms. STABENOW. Mr. President, this is a very important amendment to

clarify, once again, that we are not cutting any Medicare benefits. We are not cutting any of the guaranteed Medicare benefits people receive right now. In fact, AARP, which has been saying this on its Web site for months, has released a letter now. It quotes this sentence:

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

Not only AARP but the Association for the Protection of Medicare and Social Security, the Alliance for Retired Americans, and other seniors organizations all agree.

What we are talking about is saving Medicare, cutting down on overpayments that have been in place. Right now, 80 to 85 percent of the seniors who get their benefits, their health care, through traditional Medicare are paying more in premiums, according to the Congressional Budget Office, than they otherwise would, because MedPAC estimates we are paying about $12 billion more for people in the private for-profit insurance system right now that is called Medicare Advantage. The majority of seniors are subsidizing high insurance company profits and overpayments. What we have done in this bill is take out the overpayments and, in fact, put in competition, competitive bidding. I thought that was something our colleagues on the other side of the aisle supported—competitive bidding for reimbursements so we are not continuing the overpayments in Medicare Advantage that are causing Medicare to go broke much sooner and causing the majority of seniors to subsidize high insurance company profits.

What we are seeing on the effort, unfortunately, of my friends on the other side of the aisle is an effort to support huge subsidies instead of supporting competitive bidding that is in the bill.

The reality is that the guaranteed benefits—inpatient care, doctor visits, lab tests, preventive screenings, skilled nursing facilities, hospice care, home health care, prescription drugs, ambulance services, durable medical equipment, emergency room care, kidney dialysis, outpatient mental health care, occupational and physical therapy, imaging such as x-ray, EKGs, organ transplants, and the ''Welcome to Medicare'' physical are all covered, as they have been, for all Medicare beneficiaries.

What we are doing is taking overpayments to for-profit insurance companies and putting that back into increased benefits for every senior. That is cutting down on prescription drug costs by closing the doughnut hole and strengthening preventive care. And the most important piece of all: lengthening the solvency of the Medicare trust fund.

I urge the adoption of my amendment at the appropriate time.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I yield 2 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

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

I ask unanimous consent to have that phrase ''guaranteed by law'' be eliminated from the amendment.

The PRESIDING OFFICER. Is there objection?

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

The PRESIDING OFFICER. Objection is heard.

The time of the Senator from Florida has expired.

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

The PRESIDING OFFICER. The Senator from Ohio.

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

I refer to a Dow Jones story entitled ''Humana 3rd Quarter Profits Up 65%, See Strong Medicare Advantage Gains.''

Let me excerpt from the first few paragraphs.

Humana Inc.'s third-quarter earnings rose 65% amid improved margins at its government (i.e. Medicare Advantage) segment. The company gave an initial 2010 forecast in which the health insurer projects ''substantial'' Medicare Advantage membership growth, resulting in revenue of $32 billion to $34 billion—well above analysts' average estimate of $29.63 billion. Humana's forecast takes into account reductions in Medicare Advantage over-payments.

As the Senator from Rhode Island knows and the Presiding Officer and my colleagues who have been strong supporters of Medicare, when we see people who have opposed Medicare, opposed the creation of Medicare 40 years ago, tried to privatize Medicare with Speaker Gingrich down the Hall in the House of Representatives a dozen years ago, now they are Medicare's biggest defenders? I don't think so. They have been the insurance industry's biggest defenders. That is what the debate the last 3 days was all about. What is important is we guarantee Medicare services, as we will. We quit subsidizing insurance companies, as we should. And then that $90 tax every Medicare beneficiary has to pay, that $90 that goes to insurance subsidies, will be taken away so Medicare fee-for-service, regular Medicare members, which is 81, 82, 83 percent of Medicare beneficiaries, won't be paying that insurance company Republican tax they have had to pay ever since Medicare Advantage subsidies to insurance companies were increased.

We need to get this bill moving. The stalling and delays should be over.

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

Mr. HARKIN. Parliamentary inquiry: How much time remains?

The PRESIDING OFFICER. The Senator from Iowa controls 6 minutes 45 seconds, and the Senator from Iowa controls 2 minutes 24 seconds.

Mr. GRASSLEY. I yield 1 minute to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Mr. President, it was interesting to hear my friend from Ohio. I plan to support the Hatch amendment regarding Medicare Advantage, but it is not because I don't believe we need to do some things to cause Medicare to be more solvent. I do believe that Medicare Advantage does have some subsidies to insurance companies that are higher than they should be. The fact is, this bill is taking money from a program that is insolvent, Medicare, and using that to create an entitlement. I will support the Hatch amendment, even though I would love to work with my friends on the other side of the aisle to do those

things, to make Medicare more solvent, but I think what is so objectionable to all of us is to know that we have an insolvent Medicare Program that the trustees have said will be bankrupt in the year 2017, and my friends on the other side of the aisle are taking money from that program to leverage a new entitlement.

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

Who yields time?

Mr. HARKIN. I yield 2 minutes to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, this is a basic choice. Will we continue to subsidize private health insurance companies that are overcharging the Medicare Program by 14 percent? Will we take that money out of Medicare to continue the subsidy for profitable private health insurance companies? It is that basic. I say to the Senator from Tennessee, the Congressional Budget Office tells us, yes, untouched, the Medicare program in 7 or 8 years faces insolvency. But this bill adds 5 years of solvency to Medicare right off the top—something he won't acknowledge but he should. Let me also add, if we are going to bring down the cost of Medicare so that recipients get quality care, we have to get rid of these outrageous subsidies to private health insurance companies, the Medicare Advantage Program. We also have to be honest about those providers overcharging Medicare. Why does it cost twice as much in Miami for the same service that is given to Medicare patients in Rochester, MN? It should not. Somebody is ripping off the system. If we can't ask those honest questions, then I am afraid we will not put Medicare on sound financial footing. We can do that. But we can't do that by saying: We have got to continue to subsidize private health insurance companies out of Medicare. That is the Hatch amendment. That is what we should vote against.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

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

The PRESIDING OFFICER. The Senator has 5 minutes.

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

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

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

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

The PRESIDING OFFICER. Who yields time?

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

Mrs. HUTCHISON. I yield 30 seconds to Senator MCCAIN.

The PRESIDING OFFICER. The Senator from Arizona.

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

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

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

Who yields time?

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

The PRESIDING OFFICER. There is 2½ minutes.

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

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

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

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

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

Here is Virginia:

> I don't currently need the services under the CLASS Act, but having been born with a disability I've always been acutely aware of the possibility of serious issues down the road . . . it would be a good thing for me, a thirty-year-old working person, [to be able to put some money away.]

I beg my colleagues, for the sake of people with disabilities, let's not adopt the amendment of the Republicans to take away the CLASS Act. It was Senator Kennedy's premier goal.

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

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

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

In large part, through my efforts, the Money Follows the Person Rebalancing

Act, and the option for States to implement a home- and community-based services program were included in the Deficit Reduction Act of 2005.

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

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

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

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

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

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

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

It is the classic ''insurance death spiral.''

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

The Chief Actuary said:

There is a significant risk the problem of adverse selection would make the CLASS program unsustainable.

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

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

But sometime afterwards, it starts to lose money.

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

Look at the financial struggles of Social Security. Look at Medicare. Look at Medicaid.

Now go home and look at your children and grandchildren.

Voting to protect the premiums of a program that you know will fail is irresponsible.

Creating the unsustainable CLASS Act is irresponsible.

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

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

Mr. President, I ask unanimous consent to have printed in the RECORD two items. First is an article from Fortune magazine on the CLASS Act. Second is a letter signed by seven of my Democratic colleagues objecting to the CLASS Act.

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

[From Fortune Magazine, Sept. 3, 2009]

THE CRAZY MATH OF HEALTH-CARE REFORM

(By Shawn Tully)

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

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

The plan, which would provide modest benefits to people who can't perform such simple daily tasks as bathing or feeding themselves, was one of Sen. Ted Kennedy's last crusades. It quickly became a favorite among Democrats, who are now adding the CLASS Act to the leading proposal in the House, H.R. 3200, passed by the Energy & Commerce Committee.

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

The Democrats are promising a ''deficit neutral'' plan, which means that according to rules set by the Congressional Budget Office, they need to find about $1 trillion in new taxes and savings over the next ten years. Right how, the House legislation stands around $250 billion short.

The CLASS Act looks like a gift: It brings in $58 billion in net tax revenues by 2019, lowering the deficit by an equivalent amount because only minor costs will be booked during that period. Under the CBO rules, the CLASS Act technically covers one-quarter of the $250 billion shortfall in funds needed to pay for health-care reform.

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

In fact, none of the $58 billion is available to pay for the House bill. The CLASS Act is so poorly designed that the $58 billion reserve and all future premiums won't come close to covering the generous benefits it's promising.

Here's why the mechanics of the CLASS Act assure its eventual collapse.

Under the bill, all working Americans would have the option of contributing a payroll tax averaging $65 a month for long-term care. The eventual benefit for most recipients would be $75 a day or $27,000 a year.

It could be used towards nursing-home expenses, but the main goal is to allow infirm Americans to get the care they need from aides or therapists in their own homes so they're not forced into nursing homes.

But the CLASS Act's premiums aren't remotely high enough to cover a likely deluge of claims. ''It's a microcosm of many of the weaknesses in the health-care reform bills,'' says Steve Schoonveld of the American Academy of Actuaries (AAA), which did an excellent analysis of the CLASS Act.

The plan's main problem is that it encourages what's known as ''adverse selection''—it will attract an extremely high proportion of people who are sick and near retirement, and a relatively small share of the young and healthy needed to create a sound insurance plan.

One big weakness is that the CLASS Act doesn't screen for medical problems, or even require information about them. Hence, workers or their spouses can sign up even if they're already ill. By contrast, private plans require strict testing.

Participants in the CLASS program can also start collecting benefits after just five years, a period the AAA deems far too short. Workers and their spouses can also stop paying premiums, then rejoin when they get sick with no penalty.

As a result, the AAA expects that the plan will be swamped by people who know they have medical problems when they sign up, and demand benefits right after they've paid for five years.

The AAA says that the plan would become insolvent by 2021—just beyond the CBO's budget window—and would have to raise its premiums to $180 a month to meet its costs, a 177% increase.

That would put the CLASS Act into a death spiral, since virtually all younger and even moderately healthy participants would drop out. It would become a program exclusively for the old and sick, driving premiums still higher.

The most likely outcome is that we'll never get to the $180 premiums needed to fund the plan. Congress will be forced to pay enormous subsidies to keep the premiums low enough to encourage young and healthy people to sign up. Pressure will also be intense to raise the benefits to pay for more nursing-home expenses.

Instead of funding the shortfall in the House bill, the CLASS Act will create a giant budget shortfall of its own. Unfortunately, gimmickry like this is the kind of thing that has fanned public fears about health-care reform doing more harm than good.

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

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

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

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

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

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

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

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

Sincerely,

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

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

All time has expired.

Under the previous order, the question is on agreeing to amendment No. 2870, offered by the Senator from Rhode Island, Mr. WHITEHOUSE.

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

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

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

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

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

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

[Rollcall Vote No. 359 Leg.]

YEAS—98

Akaka	Ensign	Lugar
Alexander	Enzi	McCain
Barrasso	Feingold	McCaskill
Baucus	Feinstein	McConnell
Bayh	Franken	Menendez
Begich	Gillibrand	Merkley
Bennet	Graham	Mikulski
Bennett	Grassley	Murkowski
Bingaman	Gregg	Murray
Bond	Hagan	Nelson (NE)
Boxer	Harkin	Nelson (FL)
Brown	Hatch	Pryor
Brownback	Hutchison	Reed
Burr	Inhofe	Reid
Burris	Inouye	Risch
Cantwell	Isakson	Roberts
Cardin	Johanns	Rockefeller
Carper	Johnson	Sanders
Casey	Kaufman	Schumer
Chambliss	Kerry	Sessions
Coburn	Kirk	Shaheen
Cochran	Klobuchar	Shelby
Collins	Kohl	Snowe
Conrad	Kyl	Specter
Corker	Landrieu	Stabenow
Cornyn	Lautenberg	Tester
Crapo	Leahy	Thune
DeMint	LeMieux	Udall (CO)
Dodd	Levin	Udall (NM)
Dorgan	Lieberman	Vitter
Durbin	Lincoln	Voinovich
Warner	Webb	Wicker
	Whitehouse	Wyden

NOT VOTING—2

Bunning Byrd

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

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

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

Mrs. HUTCHISON. Thank you, Mr. President.

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

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 2901

The PRESIDING OFFICER. Under the previous order, there is 2 minutes equally divided.

Who yields time?

The Senator from Connecticut is recognized.

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

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

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

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

The PRESIDING OFFICER. Who yields time?

The Senator from South Dakota is recognized.

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

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

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

I urge my colleagues to adopt this amendment.

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

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

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

The clerk will call the roll.

The bill clerk called the roll.

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

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

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

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

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

[Rollcall Vote No. 360 Leg.]

YEAS—51

Alexander	DeMint	McCain
Barrasso	Ensign	McCaskill
Baucus	Enzi	McConnell
Bayh	Graham	Murkowski
Bennett	Grassley	Nelson (NE)
Bond	Gregg	Risch
Brownback	Hatch	Roberts
Burr	Hutchison	Sessions
Carper	Inhofe	Shelby
Chambliss	Isakson	Snowe
Coburn	Johanns	Thune
Cochran	Kyl	Udall (CO)
Collins	Landrieu	Vitter
Conrad	LeMieux	Voinovich
Corker	Lieberman	Warner
Cornyn	Lincoln	Webb
Crapo	Lugar	Wicker

NAYS—47

Akaka	Gillibrand	Murray
Begich	Hagan	Nelson (FL)
Bennet	Harkin	Pryor
Bingaman	Inouye	Reed
Boxer	Johnson	Reid
Brown	Kaufman	Rockefeller
Burris	Kerry	Sanders
Cantwell	Kirk	Schumer
Cardin	Klobuchar	Shaheen
Casey	Kohl	Specter
Dodd	Lautenberg	Stabenow
Dorgan	Leahy	Tester
Durbin	Levin	Udall (NM)
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden
Franken	Mikulski	

NOT VOTING—2

Bunning Byrd

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

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 2899

The PRESIDING OFFICER. There will now be 2 minutes of debate, equally divided, on the Stabenow amendment.

Who yields time?

The Senator from Michigan is recognized.

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

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

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

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

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, regarding this amendment, I had a conversation with my colleague from Michigan. The phrasing ''guaranteed by law'' doesn't guarantee anything. This isn't going to protect the benefits of Medicare Advantage. The benefits our senior citizens enjoy, such as eye care, hearing care, and dental care, are not protected by this. You can vote for it if you want to. It sounds good, but it is gift wrapping on an empty box.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2899, offered by the Senator from Michigan, Ms. STABENOW.

Ms. STABENOW. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

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

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

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

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

The result was announced—yeas 97, nays 1, as follows:

[Rollcall Vote No. 361 Leg.]

YEAS—97

Akaka	Feinstein	Merkley
Alexander	Franken	Mikulski
Barrasso	Gillibrand	Murkowski
Baucus	Graham	Murray
Bayh	Grassley	Nelson (NE)
Begich	Gregg	Nelson (FL)
Bennet	Hagan	Pryor
Bennett	Harkin	Reed
Bingaman	Hatch	Reid
Bond	Hutchison	Risch
Boxer	Inhofe	Roberts
Brown	Inouye	Rockefeller
Brownback	Isakson	Sanders
Burr	Johanns	Schumer
Burris	Johnson	Sessions
Cantwell	Kaufman	Shaheen
Cardin	Kerry	Shelby
Carper	Kirk	Snowe
Casey	Klobuchar	Specter
Chambliss	Kohl	Stabenow
Cochran	Kyl	Tester
Collins	Landrieu	Thune
Conrad	Lautenberg	Udall (CO)
Corker	Leahy	Udall (NM)
Cornyn	LeMieux	Vitter
Crapo	Levin	Voinovich
DeMint	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Lugar	Whitehouse
Durbin	McCain	Wicker
Ensign	McCaskill	Wyden
Enzi	McConnell	
Feingold	Menendez	

NAYS—1

Coburn

NOT VOTING—2

Bunning Byrd

The PRESIDING OFFICER. On this vote, the yeas are 97; the nays are 1. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is agreed to.

Mrs. MURRAY. Mr. President, I move to reconsider the vote.

Mr. BROWN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MOTION TO COMMIT

The PRESIDING OFFICER. Under the previous order, there is 2 minutes equally divided prior to a vote in relation to the motion to commit offered by the Senator from Utah, Mr. HATCH.

Who yields time?

Mr. BAUCUS. Mr. President, the pending motion would strike the savings the bill achieves from Medicare Advantage.

Why are we seeking savings from Medicare Advantage? Because MedPAC tells us that the government pays the private insurance companies that provide Medicare Advantage 14 percent more than we pay traditional Medicare; because these extra subsidies to Medicare Advantage cost the four-fifths of seniors in traditional Medicare $90 more a year in premiums even though they get no benefits from Medicare Advantage; because MedPAC says that ''the additional Medicare Advantage payments hasten the insolvency of the Medicare Part A trust fund by 18 months; because the private insurance companies that provide Medicare Advantage are making three-quarters of their profits from these government overpayments, and they can find some of the savings there; because private insurance companies that provide Medicare Advantage are paying their CEOs $24 million, $9 million, and $8 million a year, and they could find some of the savings there; and because nothing we do in our bill reduces benefits under Medicare.

Therefore, I urge my colleagues to oppose the motion.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I urge my colleagues to support my motion to commit.

Simply put, this motion protects Medicare beneficiaries participating in the Medicare Advantage Program by eliminating the $120 billion in cuts to the Medicare Advantage Program in the Reid bill.

Let me make this point as clearly as I can. A vote against my amendment is a vote for slashing benefits for 11 million seniors and low-income Americans, including vision benefits, dental benefits, home care for chronic illness, wellness programs, disease management programs, limits on cost sharing for primary care physician visits, reduced premiums for Part B, reduced premiums for Part D, reduced cost sharing for breast and prostrate cancer screening.

When we did this, 14 Democrats, many of whom are sitting here in the Senate right now, supported this development of Medicare Advantage.

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

Mr. HATCH. Have no doubt, when you vote against my amendment, you will be voting to cut these lifesaving and life-enhancing benefits. The choice is yours and the choice is clear. Our Nation's seniors are watching.

The PRESIDING OFFICER. The question is on agreeing to the motion.

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

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

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

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

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

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

The result was announced—yeas 41, nays 57, as follows:

[Rollcall Vote No. 362 Leg.]

YEAS—41

Alexander	Cornyn	Isakson
Barrasso	Crapo	Johanns
Bennett	DeMint	Kyl
Bond	Ensign	LeMieux
Brownback	Enzi	Lugar
Burr	Graham	McCain
Chambliss	Grassley	McConnell
Coburn	Gregg	Murkowski
Cochran	Hatch	Nelson (NE)
Collins	Hutchison	Risch
Corker	Inhofe	Roberts

Sessions	Thune	Webb
Shelby	Vitter	Wicker
Snowe	Voinovich	

NAYS—57

Akaka	Franken	Merkley
Baucus	Gillibrand	Mikulski
Bayh	Hagan	Murray
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Shaheen
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Conrad	Leahy	Tester
Dodd	Levin	Udall (CO)
Dorgan	Lieberman	Udall (NM)
Durbin	Lincoln	Warner
Feingold	McCaskill	Whitehouse
Feinstein	Menendez	Wyden

NOT VOTING—2

Bunning	Byrd

The PRESIDING OFFICER. On this vote the yeas are 41, the nays are 57. Under the previous order requiring 60 votes for the adoption of this motion, the motion to commit by Mr. HATCH is withdrawn.

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

Mr. UDALL of New Mexico. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Montana is recognized.

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

AMENDMENT NO. 2905 TO AMENDMENT NO. 2786

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

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED proposes an amendment numbered 2905 to amendment No. 2786.

Mrs. LINCOLN. I ask unanimous consent the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To modify the limit on excessive remuneration paid by certain health insurance providers to set the limit at the same level as the salary of the President of the United States)

On page 2040, strike line 14 and insert the following:

(b) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—

(1) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(I) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—In the case of a taxable year in which the $500,000 amount in clauses (i) and (ii) of subparagraph (A) exceeds the dollar amount of the compensation received by the President under section 102 of title 3, United States Code, for such taxable year, such clauses shall be applied by substituting the dollar amount provided in such section 102 for such $500,000 amount.''.

(2) REVENUE INCREASE TO BE TRANSFERRED TO MEDICARE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended—

(A) by striking ''and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ''; and'', and

(C) by inserting after paragraph (2) the following new paragraph:

''(3) the revenues resulting from the application of section 162(m)(6) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Secretary's delegate.''.

(c) EFFECTIVE DATE.—The amendments made by

Mrs. LINCOLN. I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

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

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

MOTION TO COMMIT

The Senator from Nebraska [Mr. JOHANNS] moves to commit H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include cuts in payments to home health agencies totaling negative $42.1 billion.

Mr. JOHANNS. Mr. President, I rise to speak in favor of the motion that was just read. One of the things that I think is so very important about a debate on the Senate floor is we begin to understand what this legislation does to real people. We have come to understand that $466 billion in Medicare cuts that are shown over my left shoulder have real consequences to real people all across the United States. These cuts compromise care, they compromise access to services that real people need in their daily lives. Robbing these funds from Medicare to create a dramatic new entitlement program, in my judgment, is not sound policy and it is not sound government.

That is especially true in this case when the impact on seniors' health care is so profound. These cuts will reduce the quality of care many Americans are receiving today and reduce the care these Americans deserve.

I have to tell you, out of all these Medicare cuts, one of the largest headscratching cuts is the one to home health. The Senate bill cuts $42.1 billion for home health care. Home health is about 3.7 percent of the Medicare budget. It is an important program. Yet 9.1 percent of the Medicare cuts in the Senate bill are taken out of home health.

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

Maybe there is some misunderstanding about what home health provides, so let me clear up the confusion. Home health care agencies care for patients of all ages. They provide a broad range of essential health care in support services, real security in the comfort of a patient's home. Nine thousand Medicare-approved home health agencies existed in 2007. I am very pleased to report to you that 74 of those are in my home State of Nebraska. Nurses, therapists, home care aides, and others who serve elderly and disabled patients in their own homes drive nearly 5 billion miles a year to provide these much needed services. They care for about 12 million real people annually, with 428 million visits, each one providing that personal touch of care.

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

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

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

Keeping these folks out of the emergency room or the nursing home is a benefit to everybody. I don't see how anybody could argue this doesn't save tax dollars. In fact, there are statistics that support that statement. According to the National Association of Home Health Care and Hospice, an average per-visit Medicare charge for home health is $132. Let me compare that charge of $132 to 1 day at a hospital. That would cost 43 times as much, literally—$5,765 per day.

According to a study of Avalere Health:

Early use of home health care services following a hospital stay by patients with at least one chronic disease saved Medicare $1.71 billion in the 2-year period of 2005 to 2006.

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

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

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

Home health providers already have to watch their bottom line, and they are already making very hard, painful decisions. During this video conference, a nurse in rural Nebraska explained the reality to me this way:

> I can give you a human story that just happened yesterday in our agency. We had a referral from a patient that lives 90 miles away. The drive time is three hours. To do the administration takes 1½ to 2 hours. Then you come back to the office and you do at least another hour of paperwork. It would take one person's entire day to serve one patient. Regretfully, we had to say no. We just could not see her. There is no other agency close enough to help this woman.

Can you imagine? We have a person who desperately needed these services, and we are debating whether we should cut $412 billion out of this program that will impact a State such as mine to the tune of $120 million? These agencies and the services they provide absolutely are reliant on Medicare.

According to the National Association of Home Care and Hospice:

> Medicare is the largest single payer of home health care services.

When we cut the payments in a program like this, we cut access to care. These access concerns are rooted in real life experiences. Between 1998 and 2000, Medicare home health spending fell from $14 billion to $9.2 billion or negative 34 percent, as a result of congressional action between 1998 and 2000. Those actions triggered the closure of 40 percent of home health agencies and reduced access for 1.5 million Medicare beneficiaries. Access becomes a real issue. If there is no home health agency, homebound patients end up with more expensive care at hospitals and nursing homes. That costs Medicare money. But, you see, we are also cutting hospitals and nursing homes in this bill.

If there is no home health provider near an area, not only are Medicare beneficiaries hurt but all citizens who need care. Any analysis is going to come to the same conclusion.

I will quote from one:

> Studies from MedPAC and the Government Accountability Office also suggest that access is a growing problem for patients who require intensive services. In June 2003, MedPAC issued a report indicating that skilled nursing facilities care is now substituting for home health care for some patients, most likely at a much higher cost for Medicare.

I don't think these are transformational reforms. These cuts are not transformational reform. They are just plain cuts, to start a new entitlement that will hurt real people, senior citizens who need our help. That is why I am offering this motion to recommit this legislation back to the Finance Committee to strike these ill-advised home health care cuts. I will follow up. I will make sure every Member sees the impact of these cuts in their State so they can make an assessment if these cuts should be put in place and cause the kind of damage I have described this evening.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I yield Senator KLOBUCHAR 10 minutes.

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

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

Ms. KLOBUCHAR. Mr. President, I rise to speak about a true health care reform. The way I look at this in my State, it is a matter of affordability and cost. We have one of the highest percentages of people covered in the country in Minnesota. The issue is, it is becoming more and more expensive for the people to afford health care. I always try to remember three simple numbers of all the ones we will hear in the next few weeks. Those are the numbers 6, 12, and 24. Ten years ago it cost $6,000 for an average family to pay for health care a year. Now it is $12,000, with a lot of people paying a lot more. Ten years from now, if we don't do anything, it will be somewhere between $24,000 and $36,000 a year, something regular people just can't afford. It is not going in the right direction.

If we don't act, costs will continue to skyrocket. The country spent $2.4 trillion on health care last year alone. That is $1 out of every $6 spent in the economy. By 2018, national health care spending is expected to reach $4.4 trillion, over 20 percent of our entire economy. Despite spending 1½ times more per person on health care than any other country, many of our people don't even have health care coverage. Many of them are losing their coverage because of preexisting conditions or because it simply is costing too much. These costs are breaking the backs of our families and businesses. We can see here, single coverage, 1999, $2,196. Now at 2008, the last figures we have available, $4,704, a doubling. Family cost, 1999, $5,791—that is the average family's premium—now they are paying $12,680.

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

Look at it this way: Inflation usually raises the cost of most goods and services between 2 to 3 percent per year. Health care premium costs have been going up close to 8 percent a year. That is an increase Americans can't afford. Wages have not kept pace with the increase in premiums.

Look at this. Between 1999 and 2007, the average American worker saw his wages increase 29 percent. Obviously, the last few years it has not been that rosy. How much did his insurance premiums go up? One hundred twenty percent during the same time period. In other words, the health care premiums are taking out a bigger and bigger chunk of the average worker's paycheck. These costs are breaking the backs of the American taxpayer.

My colleague was talking about Medicare. The truth is, Medicare is projected to go into deficit by 2017, if we don't do anything about it.

Recent Congressional Budget Office estimates show that the majority of the projected $344 billion increase in Federal revenues are scheduled to automatically go to cover rising health care costs. Medicare—something that people who are 55 want to get when they are 65; people who are 65 want to keep until they live to the ripe old age of 95—if we don't do anything about it, is going in the red by 2017.

How do we do this? How do we get to the place where we want to go? We

must get our money's worth from our health care dollars. The problem now is, we are paying too much and we are not getting a good return on what we pay. The solution must be to get the best value for our health care dollars; otherwise costs are going to continue to wreak havoc on the backs of government, businesses, and individual families.

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

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

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

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

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

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

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

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

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

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

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

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

Mr. President, we are here on a Friday evening being told we are going to work through the weekend, maybe next weekend, all the way up to Christmas Eve, with the intent to rush through a bill that many have called—and I agree—one of the worst pieces of legislation and one of the biggest threats to health care we have ever seen here in this country. Apparently, the majority wants to rush this through and hopefully intimidate the minority into allowing it to go through by keeping us here on weekends over the holidays. But I am proud Republicans are standing together against this bill and standing with the American people to stop the Democratic government takeover of health care in America and to stop them from paying for it by cutting nearly $500 billion from Medicare and raising taxes on millions of Americans.

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

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

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

Every Democrat in the Senate has already voted for a government takeover of health care, to cut Medicare to pay for it, and to raise taxes. Some of them said they were just moving the debate forward. But I ask you, what debate? Will there be any serious consideration to take this government-run plan out of this bill? There will not be.

We have already seen there is no serious consideration to stop taking money out of Medicare to pay for it. In fact, we have had a lot of debate about

what this is going to do: to cut from Medicare, what it is going to eventually do to benefits, cut Medicare Advantage. Now we are talking about cutting home health, which is so important, particularly in rural communities and for the more elderly constituents we serve.

There is no way you could take this money out of Medicare without hurting the programs. Instead, as we look ahead at more people retiring than ever in history and Medicare being bankrupt, we need to be looking at ways that we can shore up this program so it will be there for generations to come.

Every Republican voted no. Every Republican in this Senate has stood with the American people and said no to a health care bill that takes over the most personal and private part of our lives. I am proud of our party and our leadership.

Americans have been asking to see the differences between the Republican and the Democratic Parties. I think now more than ever on this issue they are going to see the Democrats standing with government-controlled health care, cuts in Medicare, increased taxes and on the other side Republicans who are going to stay here through Christmas and New Year's or whatever it takes to stop this bill and to sit down and really reform this system in a way that will lower costs and improve care to all Americans.

We need to continue to talk about these bigger issues, particularly how it affects Medicare, and we will be doing that over the weekend. But I think we owe it to the American people to begin to open this bill and explain what is in it. I can almost guarantee you, there is not one Member of the Senate who has read it yet. We are going to try to fit this in Santa's sleigh this year so it will be delivered to every American.

I have the first part here—1,000 pages, small print, front and back—and have started going through it, putting tabs on different pages, so we can talk about the different things because sometimes they sound so extraordinary, people do not really believe they are in there. I am not sure we will ever get through the whole thing, but I just want to take a couple parts tonight and just start talking about what is really in this bill.

On page 17, in section 2713 that is titled ''Coverage Of Preventive Health Services,'' which is really our jargon for rationing, it says:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for . . .
>
> evidence-based items or services that have in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force.

We heard from this task force a few weeks ago. This may sound harmless enough, as you look at it, but let's see what the really means: ''evidence-based . . . 'A' or 'B'.'' What is not A or B? Well, just 2 weeks ago, we found out something that was not A or B. Mammograms are a C rating. And the task force came out and said it should not be covered on anyone under 50 years old. That is in the bill, that it would not cover mammograms for folks under 50 years old because it is not A or B. Because of the outcry, we had an amendment from the other side to give themselves a little bit of cover on that one medical procedure, mammograms. We passed it with some fanfare yesterday. But the fact is, there are going to be many C ratings that are not covered.

What are we going to do here in Congress over the next several years when we find constituents are not covered for things they need in retirement from Medicare? Are we going to pass bills to try to cover those individual things? What we should really do is throw out the bill that is causing the problem. We should not be rationing care to our seniors.

Let's look at another page. And I know this is not as interesting as talking about theoretical stuff. But on page 33, section 2719 is called the ''Appeals Process'':

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process . . .
>
> [to] provide notice to enrollees, in a culturally and linguistically appropriate manner. . . .

Now, what do we think that means? Well, in fact, in 2001—this term has been used before—the Department of Health and Human Services reported that the Department had spent $10 million to figure out what that phrase means. And we still do not know. It says: ''Health care services that are respectful of and responsive to cultural and linguistic needs.'' But what this really means to us, according to the 2000 census, is there are at least 20 languages spoken by at least 200,000 Americans in this country, and what we are putting out there is a liability for every insurance company that does not have every aspect of their plan in those 20 languages. It may sound like a simple thing, but every page of this bill, almost—as you read it, you realize it is increasing the complexity and the cost of the system here in America.

I will just cover one more of these because I hear my colleagues in the background urging me to finish. But I do think we owe it to the American people to begin to talk about what is really in this bill.

On page 39, it says, under a funding category:

> Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 to be available for expenditure for grants under paragraph (1) and subparagraph (B).

Those subparagraphs are to track the trends in premium increases of health insurance once this bill goes into effect. Mr. President, $250 million to do what the Congressional Budget Office has already told us are going to be increases. But this kind of spending and this type of bureaucracy and complexity we are creating is not going to make health care more accessible and more affordable for Americans. It is creating a complex bureaucracy with tens of thousands of workers and bureaucrats to tell doctors what to do and hospitals what to do and for us, how to manage our health care.

The Congressional Budget Office has already released a report finding that those purchasing insurance through the health insurance exchanges that are in this bill could pay up to 16 percent more for health care than we do today. Yet we are moving ahead with the bill.

I will continue throughout this weekend, and every time I get a chance to speak, to talk about more of these things that are in this bill. But, folks, this is not a bill we should deliver to the American people for Christmas this year. This is a bill that we should throw out so we can start over and have a step-by-step approach to make health insurance more affordable and available to every American.

With that, Mr. President, I yield back.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I think we are going to go back and forth here.

Mr. ROBERTS. There is no ''forth.''

Mr. BAUCUS. Sorry?

Mr. ROBERTS. There is no ''forth,'' Mr. Chairman.

Mr. BAUCUS. Well, we are going to go back and forth. Here is Senator KAUFMAN.

Mr. ROBERTS. We could go back and back, sir—I do not care—and then forth and forth.

Mr. BAUCUS. Back and forth, and forth and forth, and to and fro, and this and that it works fine for me.

The PRESIDING OFFICER (Ms. KLOBUCHAR). The Senator from Delaware is recognized.

Mr. KAUFMAN. Madam President, I ask unanimous consent to speak in morning business for up to 5 minutes.

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

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

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Madam President, I rise today in support of the motion of my good friend from Nebraska, my colleague from Nebraska, Senator JOHANNS to—the official words say: to commit the bill back to the Senate Finance Committee with instructions to strike the cuts to the Medicare home health care benefit.

What the distinguished Senator is trying to do is bring some common sense to the cuts to a very vital source of health care, not only to rural areas but all over this country, and that is home health care. The bill we are considering, the bill sometimes called the

''behind closed doors'' bill, would cut home health care by $42 billion.

The Senator from Nebraska says that is a head-scratcher, and it certainly is. It is more than a head scratcher; it is a Lizzie Borden amputation in regard to a vital program.

Home health care is critical for our seniors. Obviously, that is the truth. As the cochair of the Senate Rural Health Care Caucus, I certainly understand that. So does the Senator from Nebraska. He was saying yesterday how many times he visits his rural hospitals, rural clinics, rural hospices, and you do that a lot if you are from Nebraska or Iowa or Texas or Kansas.

At any rate, in my home State of Kansas and other rural areas, many seniors live alone or out in the country miles away from a local hospital or a doctor's office. Even if they have a very good doctor, they can't get there because of their health condition. So home health care allows those seniors the freedom and the independence to stay in their home in the comfort of knowing somebody is there assisting their health care needs. More importantly, home health care is the cost-effective care, as the Senator from Nebraska has pointed out, that keeps the senior out of a nursing home or hospital and—guess what—saves the government money. Over the long term, if you cut home health care, you are going to increase the cost in regard to nursing homes, no question about it.

In my State I have had the pleasure of being able to see firsthand, as has the Senator from Nebraska, the great work our Kansas Home Health Care Association members do every day. Last year I was invited into the home of a lovely couple in Concordia, KS, America, not too far from Nebraska, and despite having multiple health issues, Duane and Phyllis were able to stay in their home with their little dog Josie, all thanks to the services provided by a home health care aide and a home nurse.

What is going to happen to seniors such as Duane and Phyllis if we slash $42 billion from home health care payments? Forty-two billion dollars is one of the largest Medicare cuts in the whole bill next to Medicare Advantage and the hospitals. The Senator from Nebraska had that chart showing serious cuts to all of our providers. Don't forget that this cut comes on the heels of several years of additional cuts to home health care—around $35 billion all told—that already have a large percentage of Kansas home health care agencies operating at very slim or negative Medicare margins. I know the same is true in Iowa, and the same is true in Texas, in Montana, in Nebraska, and all over the country.

I keep hearing my colleagues, however, on the other side of the aisle insisting that their $½ trillion cut to all Medicare—here is the quote—''won't affect the benefits guaranteed to seniors.'' Please stop that. Please stop that. That is the most disingenuous smokescreen in this whole debate. It may be true that this bill does not explicitly cut benefits. My friends across the aisle, however, cannot deny that their cuts in reimbursements to providers will affect those benefits, because when you cut the reimbursements to providers, guess who pays the price. The patients—Duane and Phyllis and their little dog Josie. I tell you what. You come to their house and you make that argument that if you close down or make cuts to home health care, Duane is not going to like it, Phyllis is not going to like it, and Josie will bite you on your leg.

As I said, many of my Kansas home health care agencies are already operating at negative margins. Their projected share of these cuts, as provided by the distinguished Senator from Nebraska, is almost $240 million. To the Senator from Montana, the distinguished chairman of the Finance Committee, my dear friend, that is $60 million in Montana; and Nevada, where the distinguished majority leader lives, the chart that has been provided to me by the Senator, $263 million.

We have Senator CORNYN sitting right behind me here. Senator CORNYN, you are in the $6.8 billion category for Texas. I might ask the Senator, What is going to happen if you get cut $6.8 billion in regard to home health care service?

Mr. CORNYN. If the Senator will yield for a response, $6.8 billion would cut not just into the muscle but into the bone and deny a lot of elderly people, particularly in rural areas, access to care entirely.

Mr. ROBERTS. I thank the Senator. The Senator from Nebraska has already pointed out what happens in Nebraska, and I know what will happen in Kansas. Nearly two-thirds of Kansas home health care agencies will have negative margins within only 5 years, probably 2 or 3, if these cuts are allowed to occur.

How are these agencies supposed to stay in business with these kinds of cuts? The home health care benefit will be worthless to a Kansas Medicare patient whose home health care agencies will go out of business. So, yes, in fact, this bill will effectively cut benefits. Again, get rid of the smokescreen.

This doesn't apply just to the home health care benefit. The same can be said for the effect of the cuts, as demonstrated by the Senator from Nebraska, for reimbursements to hospitals. This bill is going to cost the Kansas Hospital Association $1.5 billion. They have some outside experts who came in. I asked them: What is going to be the effect of the cuts? They already have cuts. They only get reimbursed 70 percent now, and $1.5 billion on top of that. We ought to have a chart—and I am sure we will have a chart—that would show Iowa or Nebraska or any State here, Texas especially, because of the number of folks there. So hospitals, hospices, skilled nursing facilities, and all of the rest.

I want every senior to know that while maybe it is technically accurate, again, for my friends across the aisle to claim this bill doesn't cut Medicare benefits, there is no way—no way—you can slash $½ trillion from payments to providers without affecting their ability to keep their door open, especially in rural and small town America. Seniors should know they will be left with a worthless benefit. To paraphrase my friend Senator ALEXANDER from Tennessee, it would be like having a bus ticket without a bus.

Thank you, Senator JOHANNS. Thank you for the work you are doing. Thank you for this motion. I hope we are successful. I hope people will wake up and understand the severity of what these cuts will do. I urge every Member of this Senate to support Senator JOHANNS when we come to a vote on this issue.

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

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have heard a lot here today about how this is going to hurt seniors and so on and so forth, words such as ''smokescreen.'' The fact is there is no smokescreen here whatsoever. This is a very well thought out, considered policy that I think strikes a very good balance between getting care to especially seniors at home, which is so important on the one hand, and making sure there is not waste on the other hand. That is our responsibility here, to make sure the program works and works well.

I have sort of a special interest in this. My mother was in the hospital. It happened about 2 weeks ago. She fortunately is doing much better. She is out of the hospital. She has spent some time with a home health caregiver with whom I was very, very impressed. This home health person is doing a great job with my mother. I have seen other instances too, but personally I was very happy to see my mother getting very good care from a home health care nurse.

I think it is also important to remind my colleagues that this amendment is generally a retread on the McCain amendment we debated over the last few days. That is, once again, the opponents of this bill are endorsing the status quo that leaves Medicare on the brink of going bankrupt and seniors facing higher costs.

Let me remind my colleagues again what will happen if we stick with the status quo. The status quo, meaning no bill, which the other side is advocating, means Medicare will go broke in 8 years. That is the status quo. In our legislation, that will be postponed for at least 5 more years. The status quo, as in no bill, which the other side is advocating, means seniors will continue to pay higher and higher premiums and cost sharing due to wasteful overpayments to health care providers.

There is so much waste in our system. We all know there is a lot of

waste. I am quite surprised not all of our colleagues want to cut out the waste. In effect, they want to keep the waste that, unfortunately, is in our system.

The status quo also means each year billions of Medicare dollars will continue to be wasted on lining the pockets of private insurance companies. That might be a bit of a strong statement, but the fact is, some chief executives of private insurance companies are paid tens of millions of dollars to manage Medicare Programs, especially Medicare Advantage, and the status quo means that will continue.

The status quo also means seniors will continue struggling to pay for prescription drugs. The stakes for seniors in the Medicare Program have never been higher.

We have a choice. It is a very simple choice: either endorse the status quo or strengthen Medicare.

Let's talk a little bit about home health care. Regarding Medicare changes for home health providers, let me describe what is in the Senate bill. I don't think our colleagues know specifically what is in the Senate bill. That may be a strong statement to make. But if they knew what was in the bill, I think some of the statements made tonight might be a little bit different.

As most of my colleagues would agree, home health care is an extremely important benefit in the Medicare Program. We are all very strong advocates of home health care. Across the country, there are more than 9,800 home health agencies providing care to seniors in their homes. This helps seniors get better and helps them to avoid expensive rehospitalizations.

We are all champions of home health care. We would like people not to be institutionalized. It is much more appropriate to have care in the home, and home health care agencies provide that.

In Montana, home health care providers go the extra mile—literally—to provide care to patients across vast distances. In some cases, in rural areas they have to drive 100 miles just to see one patient. They are dedicated people. They go great distances and travel a long way to see very few patients.

Home health providers make a real difference in improving seniors' health, and we should support their efforts. We all very much support their efforts.

While I have great respect for the services of home health providers, we also have a responsibility to protect the Medicare Program. Unfortunately, there is almost always waste somewhere. It is a matter of judgment as to how much is waste and how much is not.

We must make sure Medicare is paying appropriately; that is, that Medicare is not overpaying for Medicare services. We must take action to root out fraud and abuse in the Medicare Program generally and where it may occur in the home health industry as well.

I think the policies in the Senate bill achieve both goals. First, the Senate bill would ''rebase'' home health payments to ensure payments reflect actual costs of providing care. These changes are based on recommendations by MedPAC, which is the independent advisory commission that advises Congress on Medicare reimbursement. It is a nonpartisan group. MedPAC advises that we rebase. What do we mean by ''rebase''?

When the current home health payments were set, seniors received an average of 31 visits per episode. Today, they receive 22 visits; that is, they get paid about the same for doing less. We are trying to make sure the payment reflects the actual services provided. The Senate bill directs CMS to rebase payments to reflect this change. It is common sense. MedPAC recommended it and thinks it has to keep up with the times. Times have changed over the years, and the payment system should reflect that change.

There is something else I think is pretty important, and most of my colleagues would agree, the Senate bill roots out fraud that, unfortunately, exists in home health care as well as in other areas of Medicare spending. It tries to root out the fraud in Medicare payments for outlier cases.

Medicare provides an extra payment today for providers—home health folks—who treat sicker people, otherwise known as outlier patients—really sick, outliers. Unfortunately, the GAO found that some providers were gaming the system and getting much more outlier payments than they deserve.

For example, the GAO found that in one Florida county alone, home health providers were receiving 60 percent of all total outlier payments. That is nationwide. One county was getting 60 percent, even though they had less than 1 percent of the total Medicare population. I don't want to just single out Florida. Other counties in the southern part of the country clearly have a grossly disproportionate amount of high outlier payments.

The Senate addresses this problem by placing a cap on the amount any individual provider can receive in outlier payments.

Another change is the bill makes ''market basket'' changes in 2011 and 2012. That was recommended by MedPAC. Why is that important? MedPAC is actually much tougher. They wanted to start in 2010. We said we will hold off a bit. We wanted to be fair to the home health providers. In addition, the bill establishes a productivity adjustment for home health providers beginning not right away, not next year or the following year but in 2015.

These changes ask home health providers—like all other providers—to offer more efficient and higher quality care over time. We are being fair about it. Very importantly, in making these changes we worked closely with the home health industry to ensure these changes were reasonable and fair.

What do we do with respect to the agencies to make sure we are fair? On the rebasing policy, MedPAC recommended that we fully implement these changes in 2011. To ensure that providers can adapt to the new payment rates, we in the Senate decided we would phase in these changes over 4 years. The home health providers support this phase in. They think it is a good idea.

On the outlier policy and the fraud changes, these policies were actually suggested to us by—guess who—the home health industry. They came to us and suggested we make some changes in outliers because too many agencies are gaming the system. They asked us to make some outlier changes and stop that gaming, to make changes to stop the fraud. They came to us and gave us some ideas. Obviously, the home health industry fully supports the changes they recommended to us. They are in this bill.

On the market basket and productivity changes, the Senate bill holds off on applying these reductions while the rebasing policy is taking effect.

This bill gives home health agencies extra time—much more time than is recommended by the very aggressive proposed changes by MedPAC, the House bill, and the administration. We say those are too aggressive. We in the Senate decided to give agencies extra time to adapt to the payment changes in the bill rather than having all these implemented at the same time as MedPAC and the House and the administration all recommended.

Finally, with respect to rural home health providers, we are all very sensitive to the special needs of rural America. What did we do about that? From 2010 to 2015, rural providers will receive a 3-percent extra payment each year. This payment will ensure that rural providers are protected as we reform the home health system.

In total, the home health changes in the Senate bill, I believe, strike a fair balance between ensuring seniors have access to home care, while also rooting out inappropriate payments from the system.

I hear some of my good friends say: Gee, these changes are going to hurt seniors. They are not going to hurt them. In fact, most of the changes are suggested by the home health care industry. I think all of us want to root out fraud and waste. Also, it is claimed that Medicare beneficiaries will be harmed by this bill. This is a scare tactic.

Let me say what the American Association of Retired Persons says about these claims that these changes in Medicare reimbursement are going to harm seniors.

AARP says:

> Opponents of the health reform won't rest. [They are] using myths and misinformation to distort the truth and wrongly suggesting that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

That is AARP. I don't suggest tonight that any of our colleagues are using myths and misinformation to distort the truth. The point is, AARP claims that is not true. They support the bill strongly.

I will remind my colleagues of some of the positive changes in the legislation. This legislation improves the solvency of the Medicare Program by 5 years. It puts $30 billion back into the pockets of seniors in the form of lower Medicare premiums. It makes prescription drugs more affordable, which is an added benefit in this bill that would not be available if the legislation is not passed. The bill guarantees that seniors can continue to see a doctor of their choosing. The bill provides free wellness and prevention benefits. Those are new benefits. They don't currently exist. It will also include fair and appropriate changes for home health that protect access to care.

I don't question the motives of my colleagues. They believe they are standing up for seniors in opposing the home health changes. But in truth they will harm them because they are hurting the Medicare Program. I don't think we want to hurt the Medicare Program. We are trying to help the Medicare Program by making these changes.

There is one other point I want to make. This is kind of interesting. I thought when I saw it—if I still have it—it is kind of interesting. The growth rate in home health care spending will continue to be very high after this legislation passes. Currently, the growth rate of the home health care industry is almost 11 percent per year. After the legislation, it will be almost an 8-percent annual growth in the home health care industry. That is much faster than the national health expenditures.

I think most things in life are a judgment call. I think one fairly decides that the changes in this bill are good for seniors and home health care providers because they are sensitive to the needs of the industry, sensitive to patients, frankly, but also responsible to the American taxpayers by making sure we are rooting out waste.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I think as the American people are listening to the debate we are having on health care reform, they are being asked to accept some pretty implausible claims. One claim is that we can take $½ trillion out of Medicare and it would not have any impact on the delivery of services to Medicare beneficiaries—$½ trillion.

I think the biggest mistake about the way this bill is paid for, with the huge tax increases and huge cuts in Medicare, is the proposal to take $½ trillion out of Medicare, including $40 billion out of home health care, in order to pay for a brandnew entitlement program, when we already know Medicare itself is on a fiscally unsustainable path.

I want to talk primarily about another aspect of these cuts, and that is the 11 million seniors, including 532,000 Texans, who will lose benefits under their Medicare Advantage Program because these are not inconsequential cuts in their benefits. They are serious. I want to talk about some real human beings, some real Texans, who are going to be affected in a negative way by these cuts.

First of all, I think it is absolutely critical for the American people to understand that Medicare itself does not provide complete coverage to seniors. That is why so many seniors end up buying supplemental insurance coverage—Medigap coverage, as it is sometimes called—in order to get their bills paid for. Medicare only pays, on average, about 80 percent to providers of what private health insurance does. That is the reason, without additional compensation, many doctors will not see a new Medicare patient. They simply cannot do it and keep their doors open to their other patients.

The truth is, Medicare Advantage was created to fix some of the flaws with Medicare fee for service to give seniors more affordable and better coordinated health care. None of us are standing up saying the proposed bill is all bad because some of the positive developments in the bill call for greater coordination of health care.

On balance, it makes things worse than it does better because of these cuts in things such as Medicare Advantage.

The President of the United States has said providing Americans with a choice of quality, affordable health care was a guiding principle for him. I agree with that statement of principle. Medicare Advantage was created for that very purpose because, as I said, Medicare itself does not always work well for patients.

Where I live in Austin, TX, which is Travis County, the last time I saw a report, only 17 percent of physicians will see a new Medicare patient because Medicare reimbursement rates are so low. Those problems are avoided in large part by Medicare Advantage because it pays physicians and providers better than Medicare fee for service.

According to the American Medical Association's 2008 national health insurance report card, Medicare—not private health insurance—but Medicare had the highest percentage and the largest number of denied medical claims. In fact, Medicare denied 10 times more medical claims than private health insurers. That is another reason why seniors deserve a choice between Medicare and private plans that will offer them better benefits.

As I mentioned, today, 11 million Americans made that choice of better benefits and better care coordination through the Medicare Advantage Program. The proposed bill, the Reid bill, will take away those choices and the benefits of those 11 million seniors by cutting about $120 billion from the program.

Many of our friends across the aisle will say we can cut $120 billion out of Medicare Advantage, and it will have no impact on delivery of services. But the Director of the Congressional Budget Office disagrees with them, who says their additional benefits will be cut roughly in half.

We need to set the record straight on these so-called overpayments allegedly going to insurance company profits. It is simply a false statement. It is not true. Our colleagues know the so-called overpayments to Medicare Advantage plans do not go into those plans. They go to seniors in the form of additional benefits. That is because, under Federal law, 75 percent of additional payments to Medicare Advantage plans are used to provide seniors with additional benefits—benefits which they would not get under Medicare fee for service, benefits such as chronic care management, hearing aids, eyeglasses, and the like. The other 25 percent of any extra payments is returned to the Federal Government.

Let's be clear. Cuts to Medicare Advantage would be taking away seniors' health care benefits for those 11 million seniors. As I mentioned, ½ million Texans are on Medicare Advantage, and the Reid bill would cut their benefits by well over half. You do not have to take my word for it. Listen to what the CBO Director, Dr. Elmendorf, said when Senator CRAPO asked him during a Finance Committee hearing. He said:

So approximately half of the additional benefit would be lost to those current Medicare Advantage policy holders?

Director Elmendorf:

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

Nearly one out of every four seniors in Texas would lose about $122 a month in health care benefits to create a new $2.5 trillion entitlement that their grandchildren will ultimately have to end up paying for. And $122 a month may not sound like a lot for people inside the beltway, but a couple from my hometown of San Antonio recently wrote to me:

Please vote to leave our Medicare Advantage plans alone. We can't afford anything else as our portfolio was wiped out in the stock market collapse last year. My wife and I have had to go back to work, and we are in our seventies.

Yet this bill would impose another $122-per-month cut in their benefits.

Another constituent of mine from Conroe, TX, wrote:

Please do what you can to protect the Medicare Advantage plans. I'm on one and it has been beneficial to me. It has saved me an enormous amount of money and given me the benefits I've needed.

Some groups that support these cuts to Medicare Advantage have a conflict of interest, to say the least, because the benefits under traditional fee for service, as I mentioned, for Medicare is about 80 percent of what private insurance will pay. In order to get coverage, in order to pay the bills, many seniors have had to buy additional insurance

coverage. For 11 million seniors, Medicare Advantage provides those benefits.

For many seniors, former employers sometimes provide wraparound plans. For retired military, TRICARE provides a wraparound plan. For many low-income seniors, Medicaid helps with cost sharing and premiums. For many other seniors, they purchase a standalone Medigap policy.

We heard from our friends across the aisle about AARP's endorsement of the Medicare cuts in the Reid bill. If it sounds odd that a seniors' advocacy group would support taking nearly $½ trillion from an already near bankrupt program, it should.

The fact is, as the Washington Post noted on October 27:

. . . But not advertised in this lobbying campaign have been [AARP's] substantial earnings from insurance royalty and the potential benefits that could come its way from many of the reform proposals . . . Democratic proposals to slash reimbursements for another program, called Medicare Advantage, are widely expected to drive up demand for private Medigap policies, like the ones offered by AARP, according to health care experts, legislative aides, and documents.

So AARP, the so-called seniors' advocacy group, is advocating for a cut in benefits to 11 million beneficiaries of Medicare Advantage. The suggestion is one reason they would do so is because they will profit from this bill because these seniors will, if they can afford it, have to go out and buy Medigap coverage from, lo and behold, entities such as AARP.

The fact is, Medicare Advantage allows private plans to innovate better and provides better coordinated care for seniors. Groups such as the Kelsey-Seybold Clinic in Houston, TX, which is basically not seeing Medicare fee-for-service patients but is seeing Medicare Advantage patients because they can afford to coordinate care, the kinds of things we know they ought to be doing to provide better care, but they cannot afford to do it on the fee-for-service Medicare.

We have had the Medicare Program around for more than 40 years. The fact is, government bureaucrats are still trying to get the complex reimbursement formulas right. We know, as the distinguished chairman of the Finance Committee has said, that under the fee-for-service program, which is part of what needs to be reformed in this health care bill, Medicare pays for volume and not value.

Some of the positive things which I have complimented the bill on is, it includes some small steps to change our current pay-for-volume program to a pay-for-value approach through various delivery system reform demonstration programs.

The irony is, Medicare did not think of these delivery system reforms; rather, Washington is finally catching up on what private sector innovators have been doing for years. We heard the distinguished Senator from Minnesota talk about the Mayo Clinic. The Mayo Clinic has been doing that. I mentioned Kelsey-Seybold in Texas. But private sector innovators have been doing this through the Medicare Advantage Program already.

The delivery system reforms in the Reid bill would allow Medicare to experiment with different approaches to changing physician incentives, such as accountable care organizations or physician quality reporting initiatives.

Will they work? I happen to think they will. We do know private sector innovators have already figured out how to change physician incentives in the sorts of ways we ought to be doing more of and not punishing by cutting Medicare Advantage.

One Medicare Advantage plan, HealthSpring, serves 20,000 seniors in my State. They have been a leader for changing incentives for physicians to focus on quality rather than quantity. I met with their leadership and heard how they have done it. What they told me is they have a collaborative partnership with their physicians. They call it Partnership for Quality. Physicians are accountable for both cost and quality based on an evidence-based set of quality measures.

The results are a win-win: better quality care leading to healthier seniors and physicians who succeed in meeting evidence-based quality standards and ultimately lower health care costs, which I thought was supposed to be one of the goals of health care reform.

Participating physicians were paid financial incentives for meeting their goal, but as a result of coordination of care and evidence-based quality standards, they actually ended up charging less and patients experienced better results too. Members needed fewer hospitalizations and emergency room visits. Preventive measures increased mammograms by 80 percent, diabetic foot exams by 360 percent, and flu vaccinations by 246 percent.

I have heard about HealthSpring's success from a couple in Farmers Branch, TX, who recently wrote to me. They said:

We had a Medicare supplemental policy for several years until they priced themselves out of the market. We are now with a Medicare Advantage plan called HealthSpring. We have been very happy with this plan and the way they are saving us money. Please do not change or eliminate this program.

Let me tell you about one other Texas company called WellMed. While the Reid bill would finally give Medicare the ability to experiment with medical homes and care coordination, a San Antonio-based company, a Medicare Advantage company called WellMed, has been using a medical home model to coordinate patient care and emphasize prevention for nearly 20 years.

To quote from an article last month in ''Inside San Antonio:''

The health care delivery model at WellMed puts the patient at the center of a team directed by a primary care physician. The team may include a nurse, health coach, hospitalist, social service worker and physician assistant.

According to WellMed CEO Dr. George Rapier, ''We really do have to bring back the old-time primary care doctor who cared for you, who was concerned about you, who was part of your family, and you were part of their family. It's a primary care physician who knows all about you. So if you need a specialist, they know the best specialist to send you to. If you need to go in the hospital, they make sure you get the appropriate care in the hospital. They are your coordinator of care. And that's really the concept of a medical home.''

There is no question in my mind that the model has been saving lives in my State. Here is a story about one Texan whose life was saved by physicians caring for him at WellMed:

For years, Crohn's disease weakened—

We will call him Ed—

Ed's immune system and left him susceptible to infections. One morning in 2001, he lacked energy to even get out of bed. His breathing became labored. He developed a cough that sounded ''wet.''

His worried wife called his primary care physician at WellMed, Dr. Marlene Sanchez, who wanted Ed hospitalized immediately so she could order a nuclear scan of his lungs. He protested.

''She told me that if he refused to go, I should call 911 and have the paramedics come get him,'' [his wife] Annette recalled. ''He heard Dr. Sanchez talking to me, the urgency in her voice, and that convinced him to go.''

The scan confirmed Dr. Sanchez's suspicions: A potentially fatal blood clot had traveled from Ed's leg to his lungs. He was successfully treated and recovered. [Ed and his wife] recently celebrated Ed's 74th birthday.

Annette credits Dr. Sanchez for saving Ed's life and for acting as a catalyst that keeps him thriving in their golden years.

''We have seen an abundance of doctors, from the cancer doctors to the dermatologist, gastroenterologist, the blood doctor, the heart specialist—Ed has gone through it all . . . and they've all been coordinated by his primary care doctor. I've been to other doctors outside WellMed and you don't get the feeling that they are communicating like this.''

Well, many Texas seniors currently enjoy these extra benefits under Medicare Advantage, such as—another benefit—the Silver Sneakers program, the Nation's leading exercise program for older Americans. This past year, one of the Silver Sneakers members personally visited my office to deliver testimonials from other Silver Sneakers members. One Texan said:

At my age I need a program to strengthen me all over but primarily to help me with my balance and coordination. I need these skills to keep me from falling and breaking my bones.

Another participant in the Silver Sneakers program said:

I am 66, have been in the Silver Sneakers program a year. Prior to that I led a sedentary life, which included many health problems. I had hypertension, high cholesterol, chronic bladder condition, and mild depression. Since coming to classes and utilizing the weights and cardio machines, my life has improved immensely. My blood pressure has dropped, my cholesterol has been

lowered, my chronic bladder condition has improved and I just feel better all around. I am no longer depressed because I look better and look forward to going to class and visiting with my friends.

These cuts in Medicare Advantage are going to have a direct impact on the benefits my constituents in Texas are benefiting from—the 532,000 Texans who are currently on Medicare Advantage—and what they are asking me—which I can't answer—is why in the world would we want to cut Medicare Advantage, which actually works, as opposed to Medicare fee for service, which does not work well? Why would we take a fiscally unsustainable program, such as Medicare, which is going insolvent in 2017, and use that to create a $2.5 trillion new entitlement program?

My constituents, the seniors who have paid into Medicare all these years, are saying: It is not fair to take the money we have paid into Medicare and use it to create yet another entitlement program and not to fix Medicare itself. So I believe we need to fix Medicare's nearly $38 trillion in unfunded liabilities. We need to fix the improper payment rate of roughly 1 out of every 10 Medicare dollars which results in somewhere on the order of a minimum of $60 billion of fraudulent payments each year. We need to put it on a fiscally sustainable path, rather than taking $½ trillion from Medicare for another ill-conceived Washington health care takeover.

I don't believe my constituents believe you can take $½ trillion out of these programs, just as they do not believe you can take more than $100 billion out of Medicare Advantage, and it will have no impact on their benefits. They don't buy it. They don't believe it, and I don't either.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, it is late in the evening. I was going to address three different issues tonight, but out of respect for Senator BAUCUS, the chairman of my committee, I am going to address just one of these issues and I will come back tomorrow morning, on Saturday, and speak on the rest of the issues.

The one issue I am going to address this evening is my support of the Senator from Nebraska and his motion to commit with instructions on the home health care aspect of this 2,074-page bill. That is Senator JOHANNS' motion. We are now considering a bill that cuts $½ trillion from a Medicare Program to fund yet another unsustainable health care entitlement program. Around $42 billion comes from cuts to home health care providers—hence the purpose of Senator JOHANNS' amendment that that not happen.

You have heard from Members on this side of the grave consequences of these cuts. Several Senators have already addressed these. These severe cuts pose a legitimate threat to beneficiaries' access to home health services. In my State of Iowa alone, there are around 160 home health agencies that provide valuable services to Medicare beneficiaries across the State. Thanks to these home health care providers, seniors in Iowa are able to live at home instead of institutional settings, such as nursing homes. These seniors place great value on being able to stay in their homes. I would have to say that in all the years I have been involved in senior issues, whether it has been chairman of the Aging Committee, or chairman and now ranking member of the Finance Committee, I haven't run into one single senior citizen in my State who said to me: I am just dying to get into a nursing home. They do not want to go there.

So that is the purpose of home health agencies, to save money, but it is to retain the quality of life, and maintain the quality of life for these citizens. I rarely hear Iowans say anything about living in a nursing home, except not to go there.

Since living at home has been found to be a more cost-effective alternative than institutional care, this results in Medicare spending less. These cuts that are in this 2,074-page Reid bill will make it even harder for Iowa home health care providers to care for Medicare beneficiaries. A good part of the Medicare home health cuts come from permanent productivity adjustments.

Let's look at the possibility—or I would say I have concluded the impossibility—of bringing greater productivity to nursing home care. You have heard this week about how Medicare's chief actuary found savings from these productivity adjustments to be very unrealistic. And just so you know that the letter I refer to from the chief actuary is real, observe this chart. You also heard this week how these permanent cuts would make it harder for providers to remain in the black. You also heard these providers might end their participation in Medicare and possibly then jeopardize access to care for beneficiaries, and probably then more people ending up in the more expensive environment of a nursing home.

The threat to access to home health care from these permanent productivity cuts isn't theoretical. It is real. Like many other Medicare providers, home health agencies provide labor-intensive services. It is because of these labor-intensive services that I raise the question and the possibility—and I say it ends up being an impossibility—for them to be more productive. There are few gadgets in home health that will increase productivity. And whatever available gadgets there are, they are unaffordable for many Iowa home health agencies because they are small operations with limited financial resources.

Home health care is about doctors, it is about nurses, and home health aides, and it is about all of these providing care to the most needy. So it is incorrect, in my judgment, to assume these providers will achieve the levels of productivity like the rest of the economy.

The HHS chief actuary's findings clearly apply to home health in my State of Iowa, as they do nationally. Just to remind you: ''The estimated savings may be unrealistic;'' and ''possibly jeopardizing access to care for beneficiaries for our seniors.'' More people in nursing homes.

Because of these cuts, the percent of Iowa home health agencies that have negative Medicare margins will increase to 75 percent. So over 120 of the 160 home health providers will have negative Medicare margins because of this 2,074-page Reid bill. Iowa providers are not alone. From ½ to 90 percent of home health agencies in States across the country would have negative Medicare margins.

I ask a unanimous consent to have printed in the RECORD three letters, which I wish to put in at various places in my remarks.

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

(See exhibits 1, 2, and 3.)

Mr. GRASSLEY. Mr. President, I have here a letter dated September 23 of this year from Val Halamadaris, the president of the National Association for Home Health and Hospice. This organization represents home health agencies across the country.

Mr. President, Mr. Halamadaris wrote this letter in response to the $43 billion in home health cuts in the Finance Committee package, which presumes to be the same number that is used in the Reid bill. In this letter, he stated:

> It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee's health reform package. Our analysis indicates that by 2016, the proposed cuts in home health care services payment rates will lead to nearly 70 percent of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama's promise that Medicare beneficiaries will not be adversely affected by health care reform will be broken.

I have yet to hear from a home health care provider in Iowa that these permanent cuts will make it easier for them to care for their Medicare beneficiaries. Instead, I hear these cuts would reduce access to home health services.

The second letter I asked to have inserted in the RECORD is from the Iowa Alliance in Home Care, and they wrote:

> Ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services for many Iowans who prefer to receive services in their home.

Not only is the chief actuary saying it, as the chart reflects, but people who are connected with the business of home health care are saying it: These permanent cuts will in fact jeopardize access to home health services in Iowa. So if the home health cuts in the Reid bill are allowed to go into effect, then

Iowa's seniors, who prefer to live full lives from their homes, will be forced to live in the more expensive settings of facilities such as nursing homes.

I believe many Members on both sides of the aisle share my concern about home health care cuts.

I have here a third letter, this one dated from July 27, 2007, and it is written to Senator BAUCUS and me.

Mr. President, I use this letter, even though it is 2 years old, because we were getting entreaties from 61 of our colleagues—of which 52 now still serve in the Senate—about a legislative proposal to cut Medicare home health payments in that year—2007—by $9.7 billion and hospice payments by more than $1.1 billion. They urged me and Senator BAUCUS, at that time, to ensure that home health and hospice providers receive full market basket inflation adjustments. They also urged us to oppose any cuts in payment rates through administrative actions.

In the letter, these Members stated that home health and hospice care ''have been demonstrated to be cost-effective alternatives to institutional care in both Medicare and Medicaid programs.'' They stated that ''reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk.''

Of these 61 Senators who signed this letter 2 years ago, 52 are currently here debating this bill in the Senate. Of those 52 Senators, 37 are from his side of the aisle who are now proposing $43 billion in cuts instead of $9.7 billion in home payment cuts and $1.1 billion in hospice payments cuts. I would think they would find these kinds of cuts three or four times—four times what we were talking about 2 years ago to be very unrealistic, and to keep home health as a viable organization going.

We also must look beyond health care when we look at the impact of these permanent cuts. I have also heard from providers in Iowa that permanent cuts such as these will make it even harder for them to keep their doors open. So around 3,500 Iowans who work at home health agencies are at risk of losing their jobs at a time when we have 10 percent unemployment, at a time when more of this country is concerned that Congress ought to be working on creating jobs, jobs, jobs as opposed to the health care issue and in some cases cutting jobs out. The Labor Department reported today that unemployment is 10 percent. Now is not the time to consider bills that increase unemployment rates.

About an hour ago, the Senator from Nebraska offered this motion I am speaking in favor of now, to send this bill to the Finance Committee with instructions to report a bill without these very enormous home health cuts that are in it. We should take this opportunity to fix the bill and then come back to the full Senate with a better bill. That is why I support the motion of the Senator from Nebraska to commit, and I urge my colleagues to do the same.

I yield the floor.

EXHIBIT 1

NATIONAL ASSOCIATION
FOR HOME CARE & HOSPICE,
Washington, DC, September 23, 2009.

Re Medicare Home Health Services.

Hon. CHARLES E. GRASSLEY,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRASSLEY: I am writing to thank you for your continued support of home care patients nationwide and to enlist your help to ensure that access to home health services remains a reality for more than 3 million senior and disabled individuals that benefit from these important services.

It is crucial to the survival of the home health services delivery system that you work to reduce the $43 billion in cuts currently contained in the Senate Finance Committee's health reform package. Our analysis indicates that by 2016, the proposed cuts in home health services payment rates will lead to nearly 70% of providers nationwide at risk of closing because their costs will exceed Medicare payments. If that occurs, President Obama's promise that Medicare beneficiaries will not be adversely affected by health care reform efforts will be broken.

Invariably, providers of services facing rate cuts always cry out that care will be lost. However, history tells us that our warning should be heeded. The Balanced Budget Act of 1997 was expected to cut home health services spending by $16.1 billion in five years. Instead, the rate changes cut over $70 billion, leading to the loss of care to nearly 1.5 million Medicare beneficiaries. That change also led to higher outlays under state Medicaid programs, as well as greater use of nursing homes, hospitals, and other institutional settings. Still today, about $17 billion is spent on home health services, as compared with about $19 billion in home health outlays in 1997.

Several factors need to be understood about the current Finance Committee proposal. First, the proposal is not consistent with MedPAC advice. The proposal reduces rates to a point where Medicare margins will average zero. MedPAC, in its deliberations, clearly recognized the need for some level of margin in order to stay in business. In fact, we understand that MedPAC's executive director, Mark Miller, informed House Ways and Means members that MedPAC did not recommend a zero margin.

Second, there is a serious misunderstanding of Medicare margins. MedPAC estimates margins for 2009 will be 12.2%. However, this estimation does not include the impact of nearly 7% in rate reductions planned by way of regulation by 2011. Further, it does not include nearly 1,700 important providers of home health services, hospital-based agencies. Also, it does not reveal that the ''average'' is made up of a very wide range of individual agency margins with over 30% below zero already. Finally, reliance on Medicare margins does not convey that the total margin of agencies is estimated at 2% with Medicaid and Medicare Advantage losses driving the overall margin down.

Third, unlike other health care providers such as hospitals, the expansion of health insurance will not bring additional business of any material level. Home health patients average nearly 80 years of age and are already insured by Medicare or Medicaid. This means that the Medicare cuts to home health agencies are not offset by new revenues from newly insured patients. Instead, the proposed cuts of over 13.5% of spending on home health services will be as real as can be.

Fourth, the home health services community has put forward a credible and substantive alternative set of proposals for reforming the Medicare payment system. While the Chairman's Mark incorporates many of these proposals, the level of cuts is unsustainable. In fact, the level of cuts exceeds the $34 billion President Obama's budget recommended by nearly $10 billion. Still, the industry's proposal itself meets or exceeds the Obama budget target.

Fifth, the home health services cuts are far disproportionate to other provider sectors. The Chairman's Mark seeks 9.4% of all the Medicare cuts from home health care while home health makes up only 3% of the Medicare program currently. That disproportionate impact is further magnified by the fact that, unlike most other health care providers and insurers, expanding health insurance will have no meaningful increase in home health care business.

This is a historic time in this country, an opportunity to secure health care for all as a fundamental right. However, these reforms should not be done at the expense of our most vulnerable senior citizens, the homebound and infirm. Your leadership on this matter is greatly appreciated. Please let us know what we can do to help you succeed.

You have my great respect and admiration, now and always.

Sincerely,

VAL J. HALAMANDARIS,
President.

EXHIBIT 2

IOWA ALLIANCE IN HOME CARE,
Des Moines, IA, December 4, 2009.

Hon. CHARLES GRASSLEY,
Ranking Member, Committee On Finance, Dirksen Senate Office Building, Washington, DC.

SENATOR GRASSLEY: I'm contacting you today to urge your assistance concerning an issue of great significance to Iowa's dedicated home care nurses and other providers of valuable and needed in-home health care services to Iowans. The Iowa Alliance in Home Care respectfully requests your support to have the Senate Finance committee report back to the Senate, in response to a motion with instructions, a modified H.R. 3590 bill that does not include cuts in Medicare payments to home health agencies totaling $42.1 billion.

Your urgent action is critically important to ensure that access to quality health care services delivered in the home setting is not compromised. Proposed cuts in Medicare home health reimbursement would be devastating as most of Iowa's home care providers (i.e. public health departments, small businesses) rely largely or exclusively on Medicare and Medicaid payment to justify their operations which includes employment for thousands of Iowans. Insufficient Medicaid home health reimbursement, recently worsened by Governor Culver's ATB state budget cuts, has been reduced by an additional 5% effective 12/1/2009. In short, ensuring that Medicare home health payments are not reduced further is essential to avoid the resulting limited or no access to home health services access for many Iowans who prefer to receive services in their own home.

Senator, thank you for your past home health care support. We would greatly appreciate your immediate attention to this most critical of needs for our Iowa home health care community.

Regards,

MARK WHEELER,
Executive Director.

EXHIBIT 3

U.S. SENATE,
Washington, DC, July 27, 2007.

Hon. MAX BAUCUS, *Chairman,*
Hon. CHARLES GRASSLEY, *Ranking Member,*
Senate Finance Committee,
Washington, DC.

DEAR CHAIRMAN BAUCUS AND RANKING MEMBER GRASSLEY: Home health and hospice have become increasingly important parts of our health care system. The kinds of highly skilled and often technically complex services that our nation's home health and hospice agencies provide have enabled millions of our most frail and vulnerable seniors and disabled citizens avoid hospitals and nursing homes. By preventing such institutional care, home health and hospice services save Medicare millions of dollars each year. Most importantly, they enable individuals to stay just where they want to be—in the comfort and security of their own homes. We therefore urge you to ensure that Medicare beneficiaries continue to have access to important home health and hospice services by supporting full market basket inflation adjustments, as provided under current law, and opposing any cuts in payment rates through administrative actions.

The Administration's FY 2008 budget includes a legislative proposal to cut Medicare home health payments by $9.7 billion and hospice payments by more than $1.1 billion over five years. It also includes additional administrative cuts in payment rates. The Medicare home health benefit has already taken a larger hit in spending reductions over the past ten years than any other Medicare benefit. In fact, home health as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today, and is projected to decline to 2.6 percent of Medicare spending by 2015. This downward spiral in home health spending began with provisions in the Balanced Budget Act of 1997 (BBA), which resulted in a 50 percent cut in Medicare home health spending by 2001—far more than the Congress intended or the Congressional Budget Office (CBO) projected.

We believe that further reductions in home health and hospice payments would be counterproductive to controlling overall health care costs. Home health and hospice care have been demonstrated to be a cost-effective alternative to institutional care in both the Medicare and Medicaid programs. In fact, the Medicare Payment Advisory Commission (MedPAC) has noted the results of a 2002 RAND study which showed ''in terms of Part A costs, episodes in an inpatient rehabilitation facility or skilled nursing facility are much more costly for Medicare than episodes of care among patients going home.'' (MedPAC's June 2005 Report to Congress).

Further reducing Medicare home health expenditures would also be in direct conflict with the Administration's desire to prioritize health care in the home as a cost-effective alternative to institutional care. During the World Health Congress in February of 2005, Secretary of Health and Human Services Michael Leavitt said: ''Providing the care that lets people live at home if they want is less expensive than providing nursing home care. It frees up resources that can help other people. And obviously, many people are happier living at home.''

Reducing Medicare home health and hospice payments would place the quality of home health care and hospice and the home care delivery system at significant risk. Several factors have contributed to the increased cost of providing care in the home over the past few years, including:

The cost of travel by clinicians to patients' homes;

The use of technology, like telehealth monitors, which is not covered by Medicare;

The need to pay significantly higher salaries for nurses, therapists, and home health aides to attract these individuals from the scarce supply of clinicians nationwide.

Many home health providers currently do not have a sufficient number of clinical staff to accept patient referrals from physicians and hospitals. As a consequence, hospital discharge planners have reported that they are finding it more difficult to refer patients for home health care. Additional cuts to the home health benefit could leave home health providers no alternative but to reduce the number of visits and/or patient admissions, which would ultimately affect access to care and clinical outcomes. In addition to these costs, hospices are also experiencing rising costs for pain management pharmaceuticals, and they are also finding that patients with shorter lengths of stay are requiring more intensive services.

In order to ensure that home health care and hospice remain a viable option for Medicare patients, we urge you to support full market basket updates for home health and hospice, as provided under current law, and to oppose any cuts in payment rates through administrative action. Thank you for your consideration of this important matter.

Sincerely,

Susan M. Collins; Russ Feingold; Christopher S. Bond; Jack Reed; Patrick J. Leahy; Arlen Specter; Norm Coleman; Sheldon Whitehouse; Robert Menendez; Ken Salaar; Barack Obama; Kent Conrad; Thomas R. Carper; Barbara Mikulski; Joe Lieberman; E. Benjamin Nelson; Daniel K. Inouye; Tom Harkin; Robert C. Byrd; Frank Lautenberg; Amy Klobuchar; Herbert Kohl; Byron L. Dorgan; Daniel K. Akaka; Barbara Boxer; Tim Johnson; Johnny Isakson; Evan Bayh; Jim Webb; Patty Murray; Chuck Hagel; Joseph R. Biden, Jr.; Robert P. Casey, Jr.; John F. Kerry; Hillary Rodham Clinton; Sherrod Brown; Christopher J. Dodd; John Thune; Carl Levin; John W. Warner; Saxby Chambliss; Ron Wyden; Mark L. Pryor; Maria Cantwell; Robert F. Bennett; Bernard Sanders; Charles E. Schumer; Richard G. Lugar; Dianne Feinstein; Larry E. Craig; John Cornyn; Benjamin L. Cardin; Edward M. Kennedy; Pete V. Domenici; Bill Nelson; Kay Bailey Hutchison; David Vitter; Pat Roberts; John E. Sununu; Mary Landrieu; Sam Brownback.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, before the Senator leaves, he is a man of great character and experience in these matters.

I have a letter from a constituent who writes to urge a vote against this health care bill. This is from Mr. Bill Eberle in Huntsville, AL. He says:

The worst part of this bill is that much of the cost will be paid for by cuts to Medicare.

I think the Senator has indicated he believes that is accurate.

He goes on to say:

I am 68 years old and I have paid into Medicare for 40 years, believing it would cover much of my health care costs when I became 65. Now I am being told that the Government has found people who need the coverage more than I do and they will cut the care for which I have paid for 40 years in order to cover people who have paid nothing into the program. It is not the Government's money. The money belongs to those of us who paid into it for so many years and are watching as it is being taken away from us.

My question to my colleague is, since the Senator has been so intimately involved with Medicare over the years, is it not true that every working American has money taken out of their paycheck to fund their Medicare and that they believe and we have a compact with them that when they reach 65, they will have the benefit of that?

Mr. GRASSLEY. When they reach age 65, they will have that benefit.

Mr. SESSIONS. Yes, 65. Yes.

Mr. GRASSLEY. To the tune of 2.9 percent of payroll. That is how much a self-employed person would pay. And an employee would pay 1.45 percent and the employer would pay 1.45 percent. Then, you know this 2074-page bill adds half a percentage point to those, so you are going to get it to a point where it is almost 2 percent for the employer, 2 percent for the employee, and it would be almost 4 percent for a self-employed person paying into this that is now going to be raided to finance a brandnew entitlement program.

Mr. SESSIONS. My constituent, then, is fundamentally correct in his concern?

Mr. GRASSLEY. I sense a great deal of resentment coming through in that letter, from the words of that letter from that person, that what he has paid into, for the probably 45 years of working before he retired—that now, with Medicare already being in jeopardy, based on the trustees' report which says that by 2017 there is not going to be any money in the trust fund, and then having $464 billion taken out of that trust fund to help finance a new entitlement program at a time when the present entitlement programs are in a great deal of financial jeopardy.

Mr. SESSIONS. I think you stated that so well. Just to reemphasize, this gentleman, Mr. Eberle, who paid into Medicare for 40 years, until he got to be 65, he got not a dime of Medicare benefit, did he?

Mr. GRASSLEY. No. The only way he would have gotten benefits is if he had become disabled before age 65.

Mr. SESSIONS. He pays into it all these years and just now gets to draw it, and people start taking it out.

I thank Senator GRASSLEY for his leadership on this issue. I think he and I come out of the soil of our States, out of the real world. My impression is that nothing comes from nothing. Would you agree? Somebody has to pay?

Mr. GRASSLEY. I say it this way. We are in a town where we are dealing with a lot of Washington nonsense, and I hope, from the rural areas of Alabama, like the State of Iowa, you bring a lot of common sense to this town where there is not a lot of it.

Mr. SESSIONS. I thank the Senator. I would say the matter is a very serious one we are dealing with. Today, I had the opportunity to talk to a very experienced person involved in health care issues for many years. I expressed my bafflement about some of the disagreements we have, about huge issues.

One of my staffers wrote down what he said. He said: ''In all my years I have never seen such transparent dishonesty in the Congress.''

He said ''it is the biggest fraud that has been perpetrated in the history of our country,'' in his opinion.

Here we have a situation. I want to say I am going to pursue this in a little more detail. I am not going to go into great length tonight. But we have an amendment—Senator BENNET offered an amendment yesterday that said we wouldn't cut guaranteed benefits for Medicare. But the way this deal is being done is they are cutting payments to providers of Medicare.

We are already reaching, as Senator GRASSLEY said, a national crisis because by 2017 we will not be able to have a surplus in Medicare, we are going into default in Medicare. Where are we going to get the money?

Could we have efficiencies? Could we save some money in Medicare? Could we do some things to keep the program afloat? Perhaps. But if we do so, should not we use it, should not we use any efficiencies in savings that we could scrape together without damaging the commitment we have to our seniors—should not we use those savings to save Medicare that is going into default? I suggest that is a moral and legal commitment.

Mr. Eberle has written to me. He has paid for 40 years. He has not been able to draw anything out of it for the 40 years he has paid into it. Now he gets ready to draw, and we are telling him we are going to cut $465 billion out of the Medicare payment. This is not a little bitty matter.

We seem to have amazing—we seem to have this dispute. One group, from the other side, says: Don't worry, we are not taking $465 billion from Medicare, and we wouldn't cut Medicare, and we don't believe in cutting Medicare, and we don't want to hurt Medicare in any way. Our side over here is saying: But you are. According to the numbers that are pretty plain in this legislation, hospitals will have a $135 billion reduction; hospices, you have $8 billion for life-ending care that has been so helpful to so many families; nursing homes have a $15 billion reduction; Medicare Advantage, $120 billion; home health agencies that Senator GRASSLEY talked about, a $42 billion reduction. Are we imagining this? Have we somehow formulated this? It all totals up to about $465 billion.

This matter, I suggest, is not going away. Either we have reality here or not. I believe the facts will show that we are raiding Medicare, we are weakening that program when it is already known to all of us in this body that Medicare is not actuarially sound.

I remember when President Bush determined, in a failed effort, to try to alter Social Security in a way that he believed would put it on a more sound footing. He got no help at all. We had many of our Senators on both sides of the aisle saying: If you really want to do something, as bad as Social Security is, Medicare is in a much worse financial fix. Why aren't you fixing it?

I remember a number of years ago, 10 or more, when Senator JUDD GREGG, then chairman of the Budget Committee, tried to come up with some legislation to contain a little of the growth in Medicare. Over 5 years, he had a plan that would contain the growth by $10 billion. Not a single Democrat voted for the Gregg proposal. Now they accuse the Republicans of trying to damage Medicare when, in fact, every penny of the $10 billion to be saved was going to be utilized to strengthen Medicare and try to keep it from going into default.

Now we are talking about taking $465 billion out of Medicare and starting a new entitlement program, a new entitlement program at the time that this Nation has just passed or just incurred the largest single deficit in the history of the American Republic, $1.4 trillion. Next year, we will be over $1 trillion, according to the Congressional Budget Office—not me.

Is this smart? To have a program that people have depended on, that we have a moral compact to support—to support our seniors who paid into this plan for 40 years, now taking money out of that to create a new program? It is, in fact, in quite a number of areas, going to cost far more than is being suggested by the people who are promoting the legislation. We are going to dig into this and try to analyze it with more clarity, but the truth is, the numbers just do not add up. They will not work. We just ought not to be establishing a new entitlement program of massive proportions in a way where we really have little concept of how it is going to play out at a time of the largest deficits this Nation has ever had, deficits that, according to our own Congressional Budget Office, will double the national debt in 5 years and triple it to $17 trillion in 10 years.

It is an unsustainable course, and one of the first things we have to do is watch how we spend our money. I talked to an individual today. He said: It is like your house is in serious need of repair. You really don't have the money to fix it. You finally decide you have to borrow money to fix the house, and instead you borrow money and add a wing onto the house.

We need to fix the house we have. We need to make sure we honor our commitment to Medicare recipients. They have already paid. That is the important point to remember. They have already paid their working life under a compact and a commitment that money would be in a fund that would be available. We ought not to be taking it away.

I urge colleagues to think about this. This is perhaps the most significant fatal flaw in the legislation. It just doesn't add up. There are others, but this one, to me, is the most dramatic, the most pernicious, the one that is most unwise. We simply need to slow down, ask ourselves how we can make our health care system better, how we can do it without breaking the bank. Aren't there some things we can do to improve health care without a huge cost? Yes, there are. Let's start with every single one of those we can agree on. If we do that, I think we could make a lot of progress.

Who knows, if this economy turns around—and we all hope it will—we would be in a better footing to consider a new benefit in the future.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

MORNING BUSINESS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak up to 10 minutes each.

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

REMEMBERING MAJOR GENERAL CHARLES BEACH, JR.

Mr. MCCONNELL. Mr. President, I am here today to remember the life of a dear friend, MG Charles Beach Jr., of Beattyville, KY. General Beach passed away this past Veterans Day, at the age of 90. He was a genuine servant to his country, his hometown, and the Commonwealth of Kentucky. While General Beach will be greatly missed, the contributions that he has made to Kentucky, and the sacrifices that he has made for this Nation, will surely live on as his legacy.

Charles Beach knew from a young age that he wanted to serve his country, and in 1940, he graduated from the Virginia Military Institute in Lexington, VA. Shortly after graduation, he completed his special training and began his active service. While in Italy in 1944, Charles became severely wounded during battle. He spent the next 8 months recovering in a military hospital and was awarded the Purple Heart.

Charles Beach joined the Army Reserves after he was released from active duty. After a short time in the Reserves, Beach was recommissioned into the U.S. Army, this time with the rank of major. In 1976, he was promoted to major general after becoming the 18th Commander of the 100th Division, where he commanded the Kentucky Army Reserve Training Division.

General Beach's contributions extended beyond his military service; he was an active member of his beloved hometown of Beattyville. The general served his community through many organizations including, as chairman of People Exchange Bank and Insurance, president of the Beattyville/Lee County Chamber of Commerce, president of September Place Retirement Village, and cofounder of a scholarship program to aid eastern Kentucky students wanting to pursue careers in medicine.

This scholarship has increased the number of doctors in eastern Kentucky.

For his service to the community, General Beach received several awards, including the Kentucky Chamber of Commerce Volunteer of the Year and the Community Bankers of Kentucky Outstanding Community Banker of the Year awards. The Beattyville/Lee County Chamber of Commerce recognized General Beach for his 58 consecutive years as president. And, Beattyville Mayor Joseph Kash described Beach as ''a true gentleman and a hero of this community. It is appropriate that his passing was on Veterans Day. He was a true patriot.''

The positive impact that General Beach has made on Kentucky and this Nation has certainly not ended with his passing. His legacy will continue to live on through the individuals and the communities he so lovingly helped lead. Known nationally for his leadership and service to our country, I know all Kentuckians join me in grieving the loss of Charles Beach.

HONORING OUR ARMED FORCES

CORPORAL ANTHONY CARRASCO, JR.

Mr. UDALL of New Mexico. Mr. President, I rise today to honor a brave son of Anthony, NM.

Army CPL Anthony Carrasco Jr. was killed November 4 after being hit by sniper fire while serving his country in Iraq. He was 25 years old.

Corporal Carrasco—or ''Tony'' as he was called by family and friends—was a husband and father and son. He and his wife Johana are expecting a child. And he had two small step-children who adored him.

Tony served as truck commander for armored vehicles. It was his job to direct his vehicle down streets infested with roadside bombs and targeted by insurgents attacking from the shadows of buildings. Tony understood the danger. He accepted the risk. And he died doing what he loved, serving a country he loved.

His fellow soldiers described Tony as an optimist. His platoon sergeant, Timothy Brown, put it best: Tony ''saw the good in everything. He was a soldier who never, ever complained.'' Sergeant Brown called Tony ''the best soldier I ever had.''

As Senators or as citizens, we cannot fully experience the sadness that Tony's family and friends are feeling. But when a soldier dies, the Nation as a whole feels the loss. We are linked to Corporal Carrasco by the ties that bind a grateful Nation to its faithful servant. His loss is ours.

Please join me in honoring Anthony Carrasco, and extending our sympathies to his wife Johana, his father Antonio, his mother Juana, and the rest of the Carrasco family.

SPECIALIST JOSEPH GALLEGOS

Mr. President, I want to acknowledge the recent passing of brave New Mexican. Joseph Gallegos, a specialist with the New Mexico Army National Guard, died of a heart attack while serving in Iraq.

While his death was not due to injuries suffered in combat, that fact does not lessen the pain of his loss.

Specialist Gallegos was 39 years old. He served with the Guard as a light wheel vehicle mechanic. When not serving his country, he worked for the Forest Service on the Carson back home in Questa, NM. Throughout his life, he also worked as a firefighter, an ambulance driver and a policeman.

Specialist Gallegos gravitated toward work that allowed him to help his fellow citizens. While working for the Forest Service, he even saved a life—spotting a burning truck one day, he saw a man inside and pulled him to safety.

As Specialist Gallegos' brother, Donald, said: ''He was always taking different jobs, but they always put him in the service of others.''

Today, I ask you to join me in thanking Specialist Gallegos' family for his service, and for his sacrifice.

TRIBUTE TO DR. GARETH PARRY

Mr. KAUFMAN. Mr. President, I wish to honor the service of a great Federal employee.

Human ingenuity is boundless. This is especially true in America, which has always been driven by an entrepreneurial spirit and a belief that nothing is impossible.

From Whitney's cotton gin to the first elevator, from the electric telegraph to the refrigerated rail car, our forbearers used their ingenuity to help build a nation. Such invention and perseverance closed the western frontier in the nineteenth century. In the century that followed, Americans continued to be pioneers on that frontier which has no end—the frontier of science.

Sixty-seven years ago this week, a team of American physicists led by Enrico Fermi conducted a critical experiment. On a cold winter's afternoon, they huddled under the stands of the old football stadium at the University of Chicago. Using graphite blocks, wooden rods, and uranium pellets, they initiated the first-ever controlled nuclear reaction.

That experiment, called ''Chicago Pile One,'' marked the beginning of the nuclear age.

Today all Americans know that the discovery of nuclear power was a mixed blessing. With it came the potential for a new form of energy to power our homes and businesses. For the first time, our naval ships could remain at sea—and on guard—for extended periods without refueling.

But with nuclear energy came nuclear weapons. These led to the dangerous prospect of the mass destruction of hundreds of cities within minutes. They brought us a generation of ''duck and cover'' and backyard fallout shelters.

Thankfully—though our nation and others continue to possess these weapons in our time—the Cold War is over. No longer are we minutes from ''mutually assured destruction'' the way we once were.

Today, peaceful nuclear energy provides a fifth of our electricity, and there are 104 civilian reactors in operation across the country.

Developing and enforcing the regulations that keep these reactors safe are the men and women of the U.S. Nuclear Regulatory Commission.

This week I wish to recognize the contribution of an outstanding public servant, Dr. Gareth Parry. Gareth has had a distinguished career at the Nuclear Regulatory Commission advancing our nuclear safety.

He is also a 2004 recipient of the distinguished Arthur S. Flemming Award for public service.

Gareth, who immigrated to this country from the United Kingdom, has over thirty years of experience in developing models for probabilistic risk analysis—or PRA. He retired this September after a long and distinguished career.

As senior adviser on PRA for the Commission's Office of Nuclear Reactor Regulation, Gareth became one of the leading experts on analyzing common cause failure and human reliability. His work led to the development of PRA standards and the use of PRA to support risk-informed decisionmaking with regard to nuclear safety.

Gareth, as a scientist and a public servant, worked hard to ensure the safety of America's civilian nuclear facilities.

The kind of work he performed is highly mathematical and complex, and it may not sound glamorous to the average American, but it is critical and contributes enormously to the security and economic well-being of our Nation.

Sixty-seven years ago, Fermi and his team first harnessed the power of the atom. Today, the men and women of the Nuclear Regulatory Commission ensure that our modern nuclear reactors continue to do so safely.

I hope my colleagues will join me in honoring the service of Dr. Gareth Parry and all who have worked—and continue to work—at the Nuclear Regulatory Commission.

EXPIRATION OF START

Mr. KAUFMAN. Mr. President, tonight, the Strategic Arms Reduction Treaty will expire, and with it the primary framework for the reduction of nuclear weapons for the last 20 years. Today, I would like to speak a few minutes about the critical importance of an offensive strategic arms reduction, and why we must establish a follow-on treaty to START.

In September, President Obama proposed a resolution to the United Nations Security Council to eliminate nuclear weapons, ban production of the fissile material, outlaw nuclear tests,

and safeguard existing weapons stockpiles. World leaders approved the resolution, joining with the President's previous statements that ''America seeks a world with no nuclear weapons.'' This is not a vision of unilateral disarmament, but a vision for multilateral action. It is a vision of working step by step with every nation to draw down nuclear arsenals together. It is a critically important goal, and one of the best ways to ensure a safer future and a safer world.

In the past few years, we have seen a rise in clandestine nuclear programs developed by rogue states, including those which have successfully acquired a nuclear arsenal. This growing threat—primarily from North Korea and Iran—underscores the value of international strategic arms treaties. These are global challenges which require global solutions and a multilateral approach. The best way to combat proliferation is unity of the international community, and I am pleased that one of the greatest successes of President Obama's policy of engagement with Iran has been a growing convergence of views identifying Iran's nuclear program as a threat not just to one region but to the world.

While multilateralism is the best way to effectively reduce the threat posed by nuclear weapons, we must look to successful bilateral agreements as a model, including START. This historic agreement laid the groundwork for a common understanding between the United States and Russia regarding nuclear weapons, and truly symbolized the end of the Cold War. It allowed us to talk about previously taboo subjects, such as the Triad and intrusive verification, and develop a shared language of expertise and evaluation that reduced our nuclear arsenals. More importantly, it provided a process of arbitration that avoids confrontation, establishes legal mechanisms to forever avoid a nuclear war.

The stability START provided allowed both the United States and Russia to reduce our nuclear stockpiles and engage in negotiations about curbing proliferation worldwide. It also built great confidence in the other as a partner. Since its inception, START has served as an enabler of global nonproliferation efforts. Now this critical treaty is set to expire, and it is time to move to establish a follow-on which reflects the requirements of the 21st century, and allows the United States and Russia to continue this valuable partnership in nonproliferation together.

This is why I am a cosponsor of legislation which provides a legal basis for extending the START verification regime, and I strongly support the work of the Obama administration—under the leadership of Assistant Secretary of State for Verification and Compliance Rose Gottemoeller—to negotiate the follow-on treaty. We owe it to Americans to place consideration of the new treaty at the top of the agenda when it is submitted, so the United States can continue to pave the way toward a safer and more secure world.

SOMALIA

Mr. FEINGOLD. Mr. President, just over 6 months ago, this Congress was abuzz with concern about piracy off Somalia's coast. Following the attack on a U.S.-flagged ship, the MV Maersk Alabama, and capture of CPT Richard Phillips, no less than five congressional committees held hearings on this topic. There was intense discussion about the steps that should be taken by our ships and our Navy to help prevent these attacks. And the State Department subsequently announced several steps it would take to combat piracy, including working with the International Contact Group on Piracy to expand the multinational naval operation to patrol the waters off Somalia's coast. The United States, China, India, Russia, the European Union and many other countries have deployed naval forces to the region that are working together to combat piracy—a remarkable show of international cooperation.

Those naval efforts have had some success. But while piracy attacks declined considerably over the summer months with the monsoon season, attacks appear to be on the rise again. The International Maritime Bureau reports that 38 ships have been attacked and 10 hijacked in the past 2 months. This includes the Maersk Alabama, which was attacked again on November 18. It also includes a supertanker carrying $20 million in crude oil that was seized this week en route from Saudi Arabia to New Orleans. The UN Secretary General warned in July that ''as a result of the military presence in the region, pirates have employed more daring operational tactics, operating further seawards, toward the Seychelles, and using more sophisticated weaponry.'' The recent attacks bear out the Secretary General's concern. Even more disconcerting, Jeffrey Gettleman of the New York Times reported this week that more Somalis and new Somali subclans are being drawn into the piracy business, attracted by the vast ransom payments.

I said back in the spring that while naval action was needed to confront these pirates, we would likely see more episodes of piracy if we did not also address the conditions on land that contribute to this problem. The recent events have proven this to be true. Both Director of National Intelligence Blair and Defense Intelligence Agency Director Army LTG Michael Maples, in their testimony before Congress earlier this year, cited lawlessness and economic problems on land in Somalia as the cause of rising piracy at sea. In the absence of local law enforcement capacity and amidst a dire economic situation, piracy is an attractive choice for many young people in northwest Somalia. The renewed piracy attacks show that this remains the case, regardless of the increased pressure from naval forces and maritime vessels adopting new defensive precautions.

Now, let me be clear: when I say we should address the conditions on land, I do not mean that we should carry out some kind of military action against those villages where the pirates are known to live, as some have suggested. In fact, such operations would do little to change those conditions and they would likely make matters worse by inciting local resentment. Nor am I in any way excusing the behavior of the criminals behind these attacks—nothing can justify their actions. What I am saying is that what is needed is a serious international commitment to help establish stability, functional governance, capable law enforcement, and economic opportunity in Somalia. As leading Somalia expert Dr. Ken Menkhaus has said, it will be impossible to end the piracy when ''the risks are so low, rewards so high and alternatives so bleak in desolate Somalia.'' Changing that equation requires real change on land.

In particular, we know that most of the pirates come from communities in northern Somalia. Yet, despite this, we have done little to directly engage the regions of Puntland and Somaliland, and their regional governments. I am not arguing that we should recognize their independence, but I believe it is in our national interest to engage these regions—diplomatically and economically—and to promote governance and stability there. It is in our interest from the standpoint of not just counterpiracy, but also counterterrorism. The terrorist threat in northern Somalia is, or should be, more apparent now than ever. Last October, terrorists attacked in Somaliland and Puntland. And last month, a well-known judge and legislator in Puntland were assassinated. We need to help both of these regions to maintain and shore up their relative stability. And in the case of Somaliland, there is a unique tradition of democratic rule that we ought to encourage, although I am disappointed that Somaliland's elections have been repeatedly postponed.

At the same time, more engagement with northern Somalia does not mean we should neglect the rest of the country. The raging conflict and resulting humanitarian crisis in central and southern Somalia is worse than ever. Just yesterday, a suicide bomber attacked a graduation ceremony in Mogadishu, killing at least 10 people, including 3 Ministers of the Transitional Federal Government. This demonstrates the fragility of the TFG, which continues to face a strengthened al Shebaab and allied militias. Over the weekend, al Shebaab, a group with links to al-Qaida, seized another major town in southern Somalia. In addition to these security challenges, the TFG has struggled to broaden its grassroots appeal or demonstrate its ability to make a difference in people's lives. The result is that the TFG is reportedly

being seen by some Somalis as a proxy of the West and little different than its predecessors. This is extremely worrisome, especially if we believe that this government offers the best chance for establishing stability and inclusive governance in Somalia.

Even more than the threat of piracy, the terrorist threat shows why we need to be paying more attention to Somalia. Al-Qaida and its affiliates continue to exploit Somalia's instability, which has real ramifications for our national security. Last month, the Justice Department announced that terrorism charges were being brought in the District of Minnesota against eight defendants for recruiting and raising funds for Somali-Americans to fight on behalf of al Shebaab. Fourteen people have now been charged in this investigation, reportedly the largest group of American citizens suspected of joining an extremist movement with links to al-Qaida. We should not equate these individuals with al-Qaida suspects, but we should be mindful of what Director of the National Counterterrorism Center Michael Leiter testified to in September—that ''the potential for al-Qaida operatives in Somalia to commission Americans to return to the United States and launch attacks against the Homeland remains of significant concern.'' Our close partners in the region—Ethiopia, Kenya, and Uganda—are also justifiably concerned about al Shebaab's threat to attack them.

Recent history has shown that there are no easy answers to Somalia's troubles. Moreover, it has shown that we can complicate and even aggravate dynamics in Somalia, and many Somalis continue to view the United States with a high level of suspicion and resentment. We need to be conscious of this. But that does not mean we should just disengage and let matters in Somalia play out, as some commentators suggest. Rather, what I believe the recent history of the United States involvement in Somalia should teach us is that we cannot afford a half-hearted or fragmented policy toward Somalia where we are not clearly communicating to Somalis our intentions and our commitment. We need a comprehensive strategy toward Somalia that includes serious, high-level diplomatic support for a sustainable and inclusive peace. I have been calling for such a strategy for nearly a decade now and I still do not believe we have one. With piracy resurging and the terrorist threat more real than ever, I hope that will finally change.

ADDITIONAL STATEMENTS

REMEMBERING TOM GRAFF

● Mrs. BOXER. Mr. President, I take this opportunity to honor the life of Tom Graff, a pioneer of the environmental movement. Mr. Graff passed away on November 12, 2009, after a long battle with cancer. He was 65.

Born in Honduras in January 1944, Tom Graff was the son of German Jewish refugees. He spent his childhood in Syracuse, NY, attending Phillips Exeter Academy. He later graduated from Harvard University, Harvard Law School, and the London College of Economics. After graduation, Tom clerked for Federal judge Carl McGowen in Washington, DC, and was a legislative assistant to New York Mayor John Lindsay. In 1970, he moved to California to work for Howard, Prim, Smith, Rice & Downs, a law firm based in San Francisco.

In 1971, Tom founded the California office of the Environmental Defense Fund. From then until 2008 when he retired, Tom served as Environmental Defense Fund's regional director. For more than 37 years, Tom worked tirelessly and passionately as an advocate for the environment. He established a new form of environmental activism based on the idea that economics could, and probably should, play a significant role in environmental policymaking. Tom believed that paying attention to how economic incentives influenced business and personal behavior was critical to bringing about environmental improvements.

Although he was involved with a number of environmental issues, it was Tom's significant contributions to water policy that left an indelible mark in California. From the American River to Mono Lake to the Sacramento-San Joaquin Delta, Tom strove to ensure that water was distributed appropriately, and that the environment got its fair share. Working together with Senator Bill Bradley of New Jersey and Congressman GEORGE MILLER of Martinez, Tom was a guiding force behind the Central Valley Project Improvement Act of 1991, a milestone in the environmental movement to protect the delta. He helped craft the historic proposal to use water markets and public subsidies that ultimately resolved the controversy around Mono Lake. He also did battle with the East Bay Municipal Utility District when it sought a second source of water from the American River, known for its abundant fall salmon run. Concerned for the health of the river, the Environmental Defense Fund filed suit against EBMUD. Seventeen years later, a landmark decision designated a baseline environmental flow need for the American River that stands to this day as a benchmark in river policy.

Throughout his career, Tom's commitment to conservation and the benefits it brought was evident in the work he did every day. His lifetime of contributions and his stewardship of the environment will not soon be forgotten.

Tom is survived by his wife Sharona Barzilay; his three children Samantha, Benjamin, and Rebecca; and two grandsons Avi and Rafael. I extend my deepest sympathies to his family.

Tom was a true pioneer and advocate for a healthy and sustainable environment, working tirelessly to provide new approaches for managing natural resources. His efforts will continue to shape California's water policies for generations to come.●

REMEMBERING MITCH DEMIENTIEFF

● Ms. MURKOWSKI. Mr. President, last April I spoke about the loss of Buddy Brown, a leader of the Athabascan people of interior Alaska, who served as president of the Tanana Chiefs Conference, Inc. Buddy died at the age of 39.

Today it is my sad duty to report the passing of another Athabascan leader and former president of the Tanana Chiefs Conference, Mitch Demientieff of Nenana. Mitch died unexpectedly on Tuesday, December 1, at the age of 57. Like Buddy, he left us too soon. He accomplished so much in a short time and was taken from us when he had so much more to give.

Mitch was first elected president of the Tanana Chiefs Conference in 1973 at the age of 20. He was elected to serve in that role again in 1987. Today, the Tanana Chiefs Conference is an economic powerhouse in interior Alaska employing hundreds of people and administering a wide range of Bureau of Indian Affairs and Indian Health Service programs on behalf of some 10,000 Native people in a territory that extends over 235,000 square miles. TCC is looked upon as a national pioneer in Indian self determination and that is in large measure due to the leadership initiatives of Mitch Demientieff. Under Mitch's leadership, TCC created a regionwide health care delivery system which is today anchored by the Chief Andrew Isaac Health Center in Fairbanks.

Mitch had the good fortune of serving as president of TCC in the run-up to passage of the Indian Self Determination and Educational Assistance Act of 1975. He positioned TCC as an early adapter of this powerful tool through which Native people rely upon their tribes, rather than the Federal Government, to deliver Federal Indian programs and services. TCC has used these authorities wisely to improve the quality of services to the people of interior Alaska and provide life changing career opportunities to Native people from Fairbanks and communities throughout its region. It also began to administer housing, lands management, tribal government assistance, public safety, education and employment and natural resources programs.

One of the characteristics that distinguish Alaska's Native people is the continued reliance on traditional ways of living in our villages. Subsistence, the use of the Earth's resources for cultural and emotional sustenance, as well as food, is the way of life in interior Alaska.

Mitch Demientieff, even while running a multi-million dollar tribal enterprise, never forgot that subsistence

is fundamental to the survival of his Native people. Whatever else might have competed for his attention subsistence came first.

In 1995, when Interior Secretary Bruce Babbitt assumed responsibility for implementing the subsistence protections of the Alaska National Interest Lands Conservation Act, he turned to Mitch as his man on the ground. Mitch chaired the Federal Subsistence Board from 1995 until 2006 protecting the subsistence interests of rural Alaskans throughout the State.

Nor did Mitch ignore the needs of his own Native village of Nenana, which sits about 60 miles south of Fairbanks. Mitch chaired both the Nenana tribe and the village Native Corporation.

I extend my condolences to Kathleen and the entire Demientieff family, a grand Alaskan family with a tradition of leadership, and all of our Native people on the loss of this Chief whose contributions were greatly respected throughout Alaska.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MEASURES DISCHARGED

The following bill was discharged from the Committee on the Homeland Security and Governmental Affairs by unanimous consent, and referred as indicated:

S. 2129. A bill to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia to provide for the establishment of a National Women's History Museum; to the Committee on Environment and Public Works.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3881. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–1A11 (CL–600), CL–600–2A12 (CL–601), CL–600–2B16 (CL–601–3A)'' ((RIN2120–AA64)(Docket No. FAA–2009–0689)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3882. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 767 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2007–28281)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3883. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; SOCATA Model TBM 700 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0557)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3884. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Fokker Model F.28 Mark 0070, 0100, 1000, 2000, 3000, and 4000 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1070)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3885. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls-Royce Corporation AE 3007A1/1, AE3007A1/3, AE 3007A1, AE 3007A1E, AE 3007A1P, AE 3007A3, AE 3007C, and AE 3007C1 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0246)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3886. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model DHC–8–102, DHC–8–103, DHC–8–106, DHC–8–201, DHC–8–202, DHC–8–301, DHC–8–311, and DHC–8–315 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1072)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3887. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; McDonnell Douglas Corporation Model DC–10–10 and DC10–10F Airplanes, Model DC–10–15 Airplanes, Model DC–10–30 and DC–10–30F (KC–10A and KDC–10) Airplanes, Model DC–10–40 and DC–10–40F Airplanes, Model MD–10–10F and MD–10–30F Airplanes, and Model MD–11 and MD–11F Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1071)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3888. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 737–300, –400, and –500 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1026)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3889. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (114); Amdt. No. 3348'' (RIN2120–AA65) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3890. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures; Amdt. No. 3349'' (RIN2120–AA65) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3891. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Mankato, MN'' ((RIN2120–AA66)(Docket No. FAA–2009–0677)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3892. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and Class E Airspace; New Orleans NAS, LA'' ((RIN2120–AA66)(Docket No. FAA–2009–0405)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3893. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of the New York, NY Class B Airspace Area; and Establishment of the New York Class B Airspace Hudson River and East River Exclusion Special Flight Rules Area'' ((RIN2120–AJ59)(Docket No. FAA–2009–0837)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3894. A communication from the Division Chief of Legislation and Regulations, Maritime Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Capital Construction Fund'' (RIN2133–AB71) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3895. A communication from the Division Chief of Legislation and Regulations, Maritime Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Agency Agreements and Appointment of Agents'' (RIN2133–AB73) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3896. A communication from the Attorney, Federal Railroad Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Adjustment of the Monetary Threshold for Reporting Rail Equipment Accidents/Incidents for Calendar Year 2008'' (FRA–2007–0018) as received during adjournment of the

Senate in the Office of the President of the Senate on November 24, 20009; to the Committee on Commerce, Science, and Transportation.

EC–3897. A communication from the Deputy Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Wassenaar Agreement 2008 Plenary Agreements Implementation: Categories 1, 2, 3, 4, 5 Parts I and II, 6, 7, 8 and 9 of the Commerce Control List, Definitions, Reports'' (RIN0694–AE58) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3898. A communication from the Secretary of the Federal Trade Commission, transmitting, pursuant to law, the Commission's fifth annual report on ethanol market concentration; to the Committee on Commerce, Science, and Transportation.

EC–3899. A communication from the Secretary of the Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled ''Guides Concerning the Use of Endorsements and Testimonials in Advertising'' (16 CFR Part 255) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Commerce, Science, and Transportation.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. KOHL (for himself and Ms. SNOWE):

S. 2836. A bill to improve the Operating Fund for public housing of the Department of Housing and Urban Development, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. LINCOLN:

S. 2837. A bill to part E of title IV of the Social Security Act to examine and improve the child welfare workforce, and for other purposes; to the Committee on Finance.

By Mr. BENNET:

S. 2838. A bill to give critical access hospitals priority in receiving grants to implement health information technology, to expand participation in the drug pricing agreement program under section 340B of the Public Health Service Act, to provide for a study and report on pharmacy dispensing fees under Medicaid, to provide for continuing funding for operation of State offices of rural health, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. KLOBUCHAR (for herself, Mr. GRAHAM, and Mr. FRANKEN):

S. 2839. A bill to amend the Torture Victims Relief Act of 1998 to authorize appropriations to provide assistance for domestic and foreign programs and centers for treatment of victims of torture, and for other purposes; to the Committee on Foreign Relations.

By Mr. MENENDEZ:

S. 2840. A bill to amend title III of the Public Health Service Act to provide for the establishment and implementation of concussion management guidelines with respect to school-aged children, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MCCONNELL (for himself, Mr. REID, Mr. NELSON of Florida, Mr. LEMIEUX, Mr. AKAKA, Mr. ALEXANDER, Mr. BARRASSO, Mr. BAUCUS, Mr. BAYH, Mr. BEGICH, Mr. BENNET, Mr. BENNETT, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BROWN, Mr. BROWNBACK, Mr. BUNNING, Mr. BURR, Mr. BURRIS, Mr. BYRD, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mrs. HAGAN, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. ISAKSON, Mr. JOHANNS, Mr. JOHNSON, Mr. KAUFMAN, Mr. KERRY, Mr. KIRK, Ms. KLOBUCHAR, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Mr. MERKLEY, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. PRYOR, Mr. REED, Mr. RISCH, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mrs. SHAHEEN, Mr. SHELBY, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. TESTER, Mr. THUNE, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. VITTER, Mr. VOINOVICH, Mr. WARNER, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN):

S. Res. 370. A resolution relative to the death of Paula F. Hawkins, former United States Senator for the State of Florida; considered and agreed to.

ADDITIONAL COSPONSORS

S. 624

At the request of Mr. DURBIN, the names of the Senator from Kansas (Mr. ROBERTS) and the Senator from Delaware (Mr. KAUFMAN) were added as cosponsors of S. 624, a bill to provide 100,000,000 people with first-time access to safe drinking water and sanitation on a sustainable basis by 2015 by improving the capacity of the United States Government to fully implement the Senator Paul Simon Water for the Poor Act of 2005.

S. 653

At the request of Mr. CARDIN, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 653, a bill to require the Secretary of the Treasury to mint coins in commemoration of the bicentennial of the writing of the Star-Spangled Banner, and for other purposes.

S. 843

At the request of Mr. LAUTENBERG, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 843, a bill to establish background check procedures for gun shows.

S. 1102

At the request of Mr. LIEBERMAN, the names of the Senator from Massachusetts (Mr. KIRK) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of S. 1102, a bill to provide benefits to domestic partners of Federal employees.

S. 1152

At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1152, a bill to allow Americans to earn paid sick time so that they can address their own health needs and the health needs of their families.

S. 1304

At the request of Mr. GRASSLEY, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1421

At the request of Mr. LEVIN, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 1421, a bill to amend section 42 of title 18, United States Code, to prohibit the importation and shipment of certain species of carp.

S. 1545

At the request of Mrs. GILLIBRAND, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1545, a bill to expand the research and awareness activities of the National Institute of Arthritis and Musculoskeletal and Skin Diseases and the Centers for Disease Control and Prevention with respect to scleroderma, and for other purposes.

S. 1553

At the request of Mr. GRASSLEY, the name of the Senator from Idaho (Mr. RISCH) was added as a cosponsor of S. 1553, a bill to require the Secretary of the Treasury to mint coins in commemoration of the National Future Farmers of America Organization and the 85th anniversary of the founding of the National Future Farmers of America Organization.

S. 1554

At the request of Mr. HARKIN, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1554, a bill to amend the Juvenile Justice and Delinquency Prevention Act of 1974 to prevent later delinquency and improve the health and well-being of maltreated infants and toddlers through the development of local Court Teams for Maltreated Infants and Toddlers and the creation of a National Court Teams Resource Center to assist such Court Teams, and for other purposes.

S. 1628

At the request of Mr. UDALL of Colorado, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 1628, a bill to amend title VII of the Public Health Service Act to increase the number of physicians who practice in underserved rural communities.

S. 1629

At the request of Mr. BURRIS, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1629, a bill to authorize the Secretary of the Interior to conduct a special resource study of the archeological site and surrounding land of the New Philadelphia town site in the state of Illinois, and for other purposes.

S. 1668

At the request of Mr. BENNET, the name of the Senator from New Hampshire (Mrs. SHAHEEN) was added as a cosponsor of S. 1668, a bill to amend title 38, United States Code, to provide for the inclusion of certain active duty service in the reserve components as qualifying service for purposes of Post-9/11 Educational Assistance Program, and for other purposes.

S. 1965

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1965, a bill to authorize the Secretary of the Interior to provide financial assistance to the State of Louisiana for a pilot program to develop measures to eradicate or control feral swine and to assess and restore wetlands damaged by feral swine.

S. 2097

At the request of Mr. THUNE, the names of the Senator from Mississippi (Mr. WICKER) and the Senator from Hawaii (Mr. INOUYE) were added as cosponsors of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2730

At the request of Mr. BROWN, the names of the Senator from West Virginia (Mr. BYRD), the Senator from Massachusetts (Mr. KIRK) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2781

At the request of Ms. MIKULSKI, the names of the Senator from Washington (Mrs. MURRAY) and the Senator from New Hampshire (Mrs. SHAHEEN) were added as cosponsors of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2782

At the request of Mrs. MCCASKILL, the name of the Senator from Montana (Mr. TESTER) was added as a cosponsor of S. 2782, a bill to provide personal jurisdiction in causes of action against contractors of the United States performing contracts abroad with respect to members of the Armed Forces, civilian employees of the United States, and United States citizen employees of companies performing work for the United States in connection with contractor activities, and for other purposes.

S. 2796

At the request of Mr. ENZI, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 2796, a bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes.

S. 2831

At the request of Mr. REED, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 2831, a bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes.

S. 2835

At the request of Mr. KERRY, the names of the Senator from California (Mrs. BOXER) and the Senator from New Hampshire (Mrs. SHAHEEN) were added as cosponsors of S. 2835, a bill to reduce global warming pollution through international climate finance, investment, and for other purposes.

AMENDMENT NO. 2789

At the request of Mr. BROWN, his name was added as a cosponsor of amendment No. 2789 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

At the request of Mr. DODD, his name and the name of the Senator from Maryland (Ms. MIKULSKI) were added as cosponsors of amendment No. 2789 intended to be proposed to H.R. 3590, supra.

At the request of Mr. FRANKEN, his name was added as a cosponsor of amendment No. 2789 intended to be proposed to H.R. 3590, supra.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2793

At the request of Mr. DORGAN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

At the request of Mr. JOHNSON, his name was added as a cosponsor of amendment No. 2793 intended to be proposed to H.R. 3590, supra.

AMENDMENT NO. 2795

At the request of Mr. LEAHY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2798

At the request of Mr. INOUYE, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of amendment No. 2798 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2862

At the request of Mr. KOHL, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 2862 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2869

At the request of Mr. NELSON of Florida, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of amendment No. 2869 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2871

At the request of Mr. BROWN, the names of the Senator from Minnesota (Mr. FRANKEN), the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from Vermont (Mr. SANDERS) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of amendment No. 2871 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KOHL (for himself and Ms. SNOWE):

S. 2836. A bill to improve the Operating Fund for public housing of the Department of Housing and Urban Development, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. KOHL. Mr. President, I rise today to discuss the Asset Management

Improvement Act of 2009, which I introduced with my colleague from Maine, Senator OLYMPIA SNOWE. This bill will help our public housing agencies deliver services to the families they serve more efficiently and effectively.

Due to a 2005 rule published by the Department of Housing and Urban Development, all public housing agencies are required to convert to asset management. Much of the guidance issued by HUD is inflexible and applies a one size fits all approach to managing housing units. HUD has treated managing every public housing program the same, when in fact, the multiple programs serve very different populations and operate in extremely different ways. Additionally, the regulations imposed by HUD have caused PHAs to lose operating funds and left many short-staffed. Finally, the asset management rules issued by HUD are incomplete and unclear, leaving PHAs uncertain of funding levels for each year. While Congress has attempted to address some of these issues through HUD Appropriations legislation, permanent fixes are necessary to ensure better guidance to PHAs.

The legislation that we introduced today will ease administrative burdens on many public housing agencies, particularly the small agencies, and ensure that they have the proper funding, guidance and support to implement the rule of asset management. I look forward to working with my colleagues to move this important piece of legislation forward.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 370—RELATIVE TO THE DEATH OF PAULA F. HAWKINS, FORMER UNITED STATES SENATOR FOR THE STATE OF FLORIDA

Mr. MCCONNELL (for himself, Mr. REID, Mr. NELSON of Florida, Mr. LEMIEUX, Mr. AKAKA, Mr. ALEXANDER, Mr. BARRASSO, Mr. BAUCUS, Mr. BAYH, Mr. BEGICH, Mr. BENNET, Mr. BENNETT, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BROWN, Mr. BROWNBACK, Mr. BUNNING, Mr. BURR, Mr. BURRIS, Mr. BYRD, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mrs. HAGAN, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. ISAKSON, Mr. JOHANNS, Mr. JOHNSON, Mr. KAUFMAN, Mr. KERRY, Mr. KIRK, Ms. KLOBUCHAR, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Mr. MERKLEY, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. PRYOR, Mr. REED, Mr. RISCH, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mrs. SHAHEEN, Mr. SHELBY, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. TESTER, Mr. THUNE, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. VITTER, Mr. VOINOVICH, Mr. WARNER, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN submitted the following resolution; which was considered and agreed to:

S. RES. 370

Whereas Paula F. Hawkins was a staunch consumer advocate and served the citizens of the State of Florida on its Public Service Commission for seven years, serving as its Chairman for three years;

Whereas Paula F. Hawkins was instrumental in passing the Missing Children's Assistance Act of 1984 and worked to help establish the National Center for Missing and Exploited Children;

Whereas Paula F. Hawkins served the people of Florida with distinction for 6 years in the United States Senate;

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable Paula F. Hawkins, former member of the United States Senate.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representative and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable Paula F. Hawkins.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2880. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2881. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2882. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2883. Ms. STABENOW (for herself, Mr. KERRY, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2884. Ms. STABENOW (for herself, Mr. KERRY, Mrs. BOXER, Ms. KLOBUCHAR, Mr. BAYH, Mr. LAUTENBERG, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2885. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2886. Mr. FEINGOLD (for himself, Ms. KLOBUCHAR, Mr. KOHL, and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2887. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2888. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2889. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2890. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2891. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2892. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2893. Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2894. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2895. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2896. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2897. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2898. Mr. LIEBERMAN (for himself, Ms. COLLINS, and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2899. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID

(for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2901. Mr. THUNE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2902. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2903. Ms. SNOWE (for herself, Mr. DURBIN, Mr. MERKLEY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2905. Mrs. LINCOLN (for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2906. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2907. Ms. KLOBUCHAR (for herself, Mr. THUNE, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2908. Ms. KLOBUCHAR (for herself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2909. Mr. NELSON, of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2910. Mr. FRANKEN (for himself, Mr. ROCKEFELLER, Mrs. LINCOLN, Mr. WHITEHOUSE, Mr. LEAHY, Mr. SANDERS, Mr. BROWN, and Mr. BEGICH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H .R. 3590, supra; which was ordered to lie on the table.

SA 2911. Mr. FRANKEN (for himself and Mr. LUGAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2912. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2913. Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2914. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2915. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2918. Mr. MENENDEZ (for himself, Ms. STABENOW, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2920. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2921. Ms. STABENOW (for herself and Mrs. MCCASKILL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2922. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2923. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BEGICH, Mr. JOHNSON, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TESTER, and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2880. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

TITLE X—DELAYED IMPLEMENTATION

SEC. 10001. DELAYED IMPLEMENTATION.

Notwithstanding any other provision of this Act, or the amendments made by this Act, such provisions or amendments shall not take effect before the date that the Board of Trustees of the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) submits an annual report to Congress under subsection (b)(2) of such section that includes a statement that such Trust Fund is projected to be solvent through 2037.

SA 2881. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 1 through 20.

SA 2882. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. PROTECTING MEDICARE BENEFICIARIES' ACCESS TO HOME HEALTH SERVICES.

Notwithstanding the provisions of, and amendments made by, sections 3131 and 3401(e), such provisions and amendments are repealed.

SA 2883. Ms. STABENOW (for herself, Mr. KERRY, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In subtitle C of title IV, insert the following at the end:

SEC. 4208. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) SHORT TITLE.—This section may be cited as the ''Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009'' or the ''ENHANCED Act of 2009''.

(b) CENTERS OF EXCELLENCE FOR DEPRESSION.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et

seq.) is amended by inserting after section 520A the following:

"SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

''(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term 'depressive disorder' means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

''(b) GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as 'centers of excellence'), which shall engage in activities related to the treatment of depressive disorders.

''(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

''(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 centers of excellence may be established; and

''(B) not later than September 30, 2016, not more than 30 centers of excellence may be established.

''(3) GRANT PERIOD.—

''(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

''(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

''(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

''(5) ELIGIBLE ENTITIES.—

''(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

''(i) be an institution of higher education or a public or private nonprofit research institution; and

''(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

''(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

''(i) evidence that such entity—

''(I) provides, or is capable of coordinating with other entities to provide, comprehensive medical services with a focus on mental health services and subspecialty expertise for depressive disorders;

''(II) collaborates with—

''(aa) other medical subspecialists to address co-occurring mental illnesses;

''(bb) community organizations; and

''(cc) other members of the network;

''(III) is capable of training health professionals about mental health; and

''(ii) such other information, as the Secretary may require.

''(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

''(i) Demonstrated capacity and expertise to serve the targeted population.

''(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally competent services.

''(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

''(iv) A history of serving the population described in clause (iii).

''(v) Proposed innovative approaches for outreach to initiate or expand services.

''(vi) Use of the most up-to-date science, practices, and interventions available.

''(vii) Demonstrated coordination and collaboration, or having a viable plan to coordinate, with a community mental health center or other community mental health resources.

''(viii) Capacity to establish cooperative agreements with other community entities to provide social and human services to individuals with depressive disorders.

''(ix) Demonstrated potential for replication and dissemination of evidence-based research and practices.

''(6) SPECIALTY CENTERS.—Of the centers of excellence receiving a grant under this section, the Secretary may select 1 or more such centers to specialize in—

''(A) subspecialties such as prepartum and postpartum depression, traumatic stress disorder, suicidal tendency, bipolar disorder, and depression; and

''(B) providing mental health services to communities with problems of access, such as rural communities and economically depressed communities.

''(7) NATIONAL COORDINATING CENTER.—

''(A) IN GENERAL.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the 'coordinating center'). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

''(B) APPLICATION.—A center of excellence that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(C) DUTIES.—The coordinating center shall—

''(i) develop, administer, and coordinate the network of centers of excellence under this section;

''(ii) oversee and coordinate the national database described in subsection (d);

''(iii) lead a strategy to disseminate the findings and activities of the centers of excellence through such database;

''(iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health; and

''(v) establish a common network infrastructure to advance services provided by the centers of excellence and demonstrate effectiveness in fostering a collaborative community among such centers for sharing knowledge and skills.

''(8) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(c) ACTIVITIES OF THE CENTERS OF EXCELLENCE.—Each center of excellence shall carry out the following activities:

''(1) GENERAL ACTIVITIES.—Each center of excellence shall—

''(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development of evidence-based interventions;

''(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop the research agenda and disseminate the research findings of such center, and to provide support in the implementation of evidence-based practices;

''(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders;

''(D) facilitate the dissemination and communication of research findings and depressive disorder-related information from the institutions of higher education to the public; and

''(E) educate policy makers, employers, community leaders, and the general public about depressive disorders to reduce stigma and raise awareness of available treatments for such disorders.

''(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, AND DIAGNOSTIC PROTOCOLS.—Each center of excellence shall collaborate with other centers of excellence in the network to—

''(A) develop and implement treatment standards, clinical guidelines, and protocols to improve the accuracy and timeliness of diagnosis of depressive disorders; and

''(B) develop and implement treatment standards that emphasize early intervention and treatment for, primary prevention and the prevention of recurrences of, and recovery from, depressive disorders.

''(3) COORDINATION AND INTEGRATION OF PHYSICAL, MENTAL, AND SOCIAL CARE.—Each center of excellence shall—

''(A) incorporate principles of chronic care coordination and integration of services that address physical, mental, and social conditions in the treatment of depressive disorders;

''(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

''(C) identify how treatment for depression interacts with such co-occurring illnesses to improve overall health outcomes;

''(D) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

''(E) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

''(4) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS OF EXCELLENCE AND COMMUNITY-BASED ORGANIZATIONS.—Each center of excellence shall—

''(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

''(B) expand multidisciplinary, translational, and patient-oriented research and treatment by fostering such collaborations; and

''(C) coordinate with accredited academic programs to provide ongoing opportunities, in academic and in community settings, for the professional and continuing education of mental health providers.

''(d) NATIONAL DATABASE.—

''(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the centers of excellence, as described in paragraph (2).

''(2) DATA COLLECTION.—

''(A) DATA.—Each center of excellence shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

''(i) the prevalence and incidence of depressive disorders;

''(ii) the health and social outcomes of individuals with depressive disorders;

''(iii) the effectiveness of interventions designed, tested, and evaluated;

''(iv) the progress in the prevention of, and recovery from, depressive disorders; and

''(v) the economic impact of the activities of such center.

''(B) FINANCIAL INFORMATION.—Each center of excellence shall provide to the coordinating center appropriately summarized financial information to enable the coordinating center to assess the efficiency and financial sustainability of such center.

''(3) SUBMISSION OF DATA TO THE ADMINISTRATOR.—The coordinating center shall submit to the Administrator the data and financial information gathered under paragraph (2).

''(4) PUBLICATION USING DATA FROM THE DATABASE.—A center of excellence, or an individual affiliated with a center of excellence, may publish findings using the data described in paragraph (2)(A) only if such center submits such data to the coordinating center, as required under such paragraph.

''(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

''(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the Administrator, shall establish performance standards for—

''(A) each center of excellence; and

''(B) the network of centers of excellence as a whole.

''(2) REPORT CARDS.—The Secretary, acting through the Administrator, shall—

''(A) for each center of excellence, not later than 3 years after the date on which such center of excellence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such center of excellence; and

''(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

''(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (1), the Secretary shall, not later than September 30, 2015—

''(A) make recommendations to the centers of excellence regarding improvements such centers shall make; and

''(B) make recommendations to Congress for expanding the centers of excellence to serve individuals with other types of mental disorders.

''(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of centers of excellence to ensure that such centers are meeting the goals of this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

''(A) $100,000,000 for each of the fiscal years 2011 through 2015; and

''(B) $150,000,000 for each of the fiscal years 2016 through 2020.

''(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each center of excellence receiving a grant under this section, but in no case may the allocation be more than $5,000,000, except that the Secretary may allocate not more than $10,000,000 to the coordinating center.''.

(c) SENSE OF THE SENATE.—It is the sense of the Senate that the knowledge and research developed by the centers of excellence for depression established under section 520B of the Public Health Service Act should be disseminated broadly within the medical community and the Federal Government, particularly to agencies with an interest in mental health, including other agencies within the Department of Health and Human Services and the Departments of Justice, Defense, Labor, and Veterans Affairs.

SA 2884. Ms. STABENOW (for herself, Mr. KERRY, Mrs. BOXER, Ms. KLOBUCHAR, Mr. BAYH, Mr. LAUTENBERG, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII, insert the following:

Subtitle C—Heart Disease Education, Analysis Research, and Treatment for Women

SEC. 7201. SHORT TITLE.

This subtitle may be cited as the ''Heart Disease Education, Analysis Research, and Treatment for Women Act'' or the ''HEART for Women Act''.

SEC. 7202. REPORTING OF DATA IN APPLICATIONS FOR DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES.

(a) DRUGS.—

(1) NEW DRUG APPLICATIONS.—Section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended—

(A) in paragraph (1), in the second sentence—

(i) by striking ''drug, and (G)'' and inserting ''drug; (G)''; and

(ii) by inserting before the period the following: ''; and (H) the information required under paragraph (7)''; and

(B) by adding at the end the following:

''(7)(A) With respect to clinical data in an application under this subsection, the Secretary may deny such an application if the application fails to meet the requirements of sections 314.50(d)(5)(v) and 314.50(d)(5)(vi)(a) of title 21, Code of Federal Regulations.

''(B) The Secretary shall modify the sections referred to in subparagraph (A) to require that an application under this subsection include any clinical data possessed by the applicant that relates to the safety or effectiveness of the drug involved by gender, age, and racial subgroup.

''(C) Promptly after approving an application under this subsection, the Secretary shall, through an Internet Web site of the Department of Health and Human Services, make available to the public the information submitted to the Secretary pursuant to subparagraphs (A) and (B), subject to sections 301(j) and 520(h)(1) of this Act, subsection (b)(4) of section 552 of title 5, United States Code (commonly referred to as the 'Freedom of Information Act'), and other provisions of law that relate to trade secrets or confidential commercial information.

''(D) The Secretary shall develop guidance for staff of the Food and Drug Administration to ensure that applications under this subsection are adequately reviewed to determine whether the applications include the information required pursuant to subparagraphs (A) and (B).''.

(2) INVESTIGATIONAL NEW DRUG APPLICATIONS.—Section 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i)) is amended—

(A) in paragraph (2), by striking ''Subject to paragraph (3),'' and inserting ''Subject to paragraphs (3) and (5),'' ; and

(B) by adding at the end the following:

''(5)(A) The Secretary may place a clinical hold (as described in paragraph (3)) on an investigation if the sponsor of the investigation fails to meet the requirements of section 312.33(a) of title 21, Code of Federal Regulations.

''(B) The Secretary shall modify the section referred to in subparagraph (A) to require that reports under such section include any clinical data possessed by the sponsor of the investigation that relates to the safety or effectiveness of the drug involved by gender, age, and racial subgroup.''.

(b) BIOLOGICAL PRODUCT LICENSE APPLICATIONS.—Section 351 of the Public Health Service Act (42 U.S.C. 262), as amended by section 7002, is further amended by adding at the end the following:

''(n) The provisions of section 505(b)(7) of the Federal Food, Drug, and Cosmetic Act (relating to clinical data submission) apply with respect to an application under subsection (a) of this section to the same extent and in the same manner as such provisions apply with respect to an application under section 505(b) of such Act.''.

(c) DEVICES.—

(1) PREMARKET APPROVAL.—Section 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360e) is amended—

(A) in subsection (c)(1)—

(i) in subparagraph (G)—

(I) by moving the margin 2 ems to the left; and

(II) by striking ''and'' after the semicolon at the end;

(ii) by redesignating subparagraph (H) as subparagraph (I); and

(iii) by inserting after subparagraph (G) the following subparagraph:

''(H) the information required under subsection (d)(7); and''; and

(B) in subsection (d), by adding at the end the following paragraph:

''(7) To the extent consistent with the regulation of devices, the provisions of section 505(b)(7) (relating to clinical data submission) apply with respect to an application for premarket approval of a device under subsection (c) of this section to the same extent and in the same manner as such provisions apply with respect to an application for premarket approval of a drug under section 505(b).''.

(2) INVESTIGATIONAL DEVICES.—Section 520(g)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j(g)(2)) is amended by adding at the end the following subparagraph:

''(D) To the extent consistent with the regulation of devices, the provisions of section 505(i)(5) (relating to individual study information) apply with respect to an application for an exemption pursuant to subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to an application for an exemption under section 505(i).''.

(d) RULES OF CONSTRUCTION.—This subtitle and the amendments made by this subtitle may not be construed—

(1) as establishing new requirements under the Federal Food, Drug, and Cosmetic Act relating to the design of clinical investigations that were not otherwise in effect on the day before the date of the enactment of this Act; or

(2) as having any effect on the authority of the Secretary of Health and Human Services to enforce regulations under the Federal Food, Drug, and Cosmetic Act that are not expressly referenced in this subtitle or the amendments made by this subtitle.

(e) APPLICATION.—This section and the amendments made by this section apply only with respect to applications received under section 505 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) on or after the date of the enactment of this Act.

SEC. 7203. REPORTING AND ANALYSIS OF PATIENT SAFETY DATA.

(a) DATA STANDARDS.—Section 923(b) of the Public Health Service Act (42 U.S.C. 299b–23(b)) is amended by adding at the end the following: ''The Secretary shall provide that all nonidentifiable patient safety work product reported to and among the network of patient safety databases be stratified by sex.''.

(b) USE OF INFORMATION.—Section 923(c) of the Public Health Service Act (42 U.S.C. 299b–23(c)) is amended by adding at the end the following: ''Such analyses take into account data that specifically relates to women and any disparities between treatment and the quality of care between males and females.''.

SEC. 7204. QUALITY OF CARE REPORTS BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

Section 903 of the Public Health Service Act (42 U.S.C. 299a–1) is amended—

(1) in subsection (b)(1)(B), by inserting before the semicolon the following: '', and including quality of and access to care for women with heart disease, stroke, and other cardiovascular diseases''; and

(2) in subsection (c), by adding at the end the following:

''(4) ANNUAL REPORT ON WOMEN AND HEART DISEASE.—Not later than September 30, 2011, and annually thereafter, the Secretary, acting through the Director, shall prepare and submit to Congress a report concerning the findings related to the quality of and access to care for women with heart disease, stroke, and other cardiovascular diseases. The report shall contain recommendations for eliminating disparities in, and improving the treatment of, heart disease, stroke, and other cardiovascular diseases in women.''.

SEC. 7205. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $70,000,000 for fiscal year 2010, $73,500,000 for fiscal year 2011, $77,000,000 for fiscal year 2012, $81,000,000 for fiscal year 2013, and $85,000,000 for fiscal year 2014.''.

SA 2885. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, insert the following:

SEC. 4109. REAUTHORIZATION OF TELEHEALTH PROGRAMS.

(a) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—Section 102(b) of the Health Care Safety Net Amendments of 2002 (42 U.S.C. 254c-17(b)) is amended by striking ''2002 through 2006'' and inserting ''2011 through 2015''.

(b) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I(s) of the Public Health Service Act (42 U.S.C. 254c-14(s)) is amended—

(1) in paragraph (1), by striking ''2003 through 2006'' and inserting ''2011 through 2015''; and

(2) in paragraph (2), by striking ''2003 through 2006'' and inserting ''2011 through 2015''.

(c) MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.—Section 330K(g) of the Public Health Service Act (42 U.S.C. 254c–16(g)) is amended by striking ''2003 through 2006'' and inserting ''2011 through 2015''.

SA 2886. Mr. FEINGOLD (for himself, Ms. KLOBUCHAR, Mr. KOHL, and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 751, between lines 2 and 3, insert the following:

SEC. 3022A. IMPROVEMENTS IN THE MEDICARE SHARED SAVINGS PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)—

(A) in paragraph (1)(D), by inserting ''or critical access hospitals'' before the period at the end; and

(B) in paragraph (2), by adding at the end the following new subparagraph:

''(I) The ACO shall take into account the special needs of hospitals located in rural areas.''; and

(2) by striking subsection (d)(1)(B)(ii) and inserting the following new clause:

''(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO that is based—

''(I) 50 percent on the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO; and

''(II) 50 percent on the national average of the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries.

Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period. In establishing the benchmarks under this clause, the Secretary implements the amendment made by section 3022A(2) in a budget-neutral manner.''.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the applicability of Accountable Care Organizations (ACOs) in rural, frontier areas. Such study shall include an analysis of—

(A) ways to demonstrate that Accountable Care Organizations or similar models might successfully form in rural, frontier areas in order to ensure that under-populated areas are able to benefit from the shared savings and care coordination offered by Accountable Care Organizations; and

(B) other areas determined appropriate by the Secretary.

(2) REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SA 2887. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1302 and insert the following:

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

In this title, the term ''essential health benefits'' means, with respect to any health plan, coverage that meets the same statutory requirements for plans offered to Members of Congress (as enumerated in section 8904(a) of title 5, United States Code).

SA 2888. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 1323, add the following:

(1) IMPLEMENTATION.—Notwithstanding any other provision of this title (or an amendment made by this title), this section shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services, in consultation with the National Association of Insurance Commissioners, certifies to Congress that the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) meets the standards for risk-based capital as established by the National Association of Insurance Commissioners.

SA 2889. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1979, strike line 20 and all that follows through page 1996, line 3, and insert the following:

SEC. 9001. CAP ON EXCESS MEDICAL INFLATION.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 4980I. EXCESS MEDICAL COSTS OF HEALTH BENEFITS PLANS.

''(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

''(b) EXCESS HEALTH PLAN COSTS.—For purposes of this section—

''(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs' means, with respect to any health benefits plan which has an excess medical inflation rate in excess of zero for any year, the product of—

''(A) the applicable premium of such health benefits plan for such year, and

''(B) the excess medical inflation rate for such plan for such year.

''(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan for any year, the amount equal to the excess of—

''(A) the core medical inflation trend rate of such health benefits plan for such year, over

''(B) the medical inflation cap for such year.

''(3) CORE MEDICAL TREND RATE.—The term 'core medical trend rate' means, with respect to any health benefits plan for any year, the amount (expressed as a percentage), if any, by which—

''(A) the actuarially adjusted premium of such plan for such plan for such year, exceeds

''(B) the applicable premium of such plan for the preceding plan year.

''(4) MEDICAL INFLATION CAP.—

''(A) YEARS 2013 TO 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2012 and before 2020, the medical inflation cap shall be the sum of—

''(I) the annualized rate of growth of the gross domestic product for the preceding calendar year (as calculated in the third quarter of the preceding year), plus

''(II) the applicable amount.

''(ii) APPLICABLE AMOUNT.—For purposes of clause (i)(II), the applicable amount shall be determined as follows:

''In the case of a plan year beginning in calendar year—	The applicable amount is—
2013	1.1 percentage points
2014	0.8 percentage points
2015, 2016, 2017, 2018, or 2019.	0.5 percentage points

''(B) YEARS AFTER 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2019, the medical inflation cap shall be equal to the amount (expressed as a percentage), if any, by which—

''(I) the average applicable premium for a low-cost plan for such calendar year, exceeds

''(II) the average applicable premium for a low-cost plan for the preceding calendar year.

''(ii) AVERAGE APPLICABLE PREMIUM FOR A LOW-COST PLAN.—For purposes of this subparagraph, the term 'average applicable premium for a low-cost plan' means the average of the applicable premiums for health benefits plans with applicable premiums below the 33rd percentile, determined by weighting such health benefits plans by the number of individuals enrolled in the plan.

''(c) APPLICABLE PREMIUM; ACTUARIALLY ADJUSTED PREMIUM.—For purposes of this section—

''(1) APPLICABLE PREMIUM.—The term 'applicable premium' has the meaning given such term under section 4980B(f)(4).

''(2) ACTUARIALLY ADJUSTED PREMIUM.—

''(A) IN GENERAL.—The term 'actuarially adjusted premium' means, for any health benefits plan for any year, the applicable premium for such year adjusted, according to actuarial standards and the method prescribed by the Secretary under subparagraph (B), by excluding any cost attributable to—

''(i) the attributes of individuals (such as age, gender, and health risk measures) covered under the plan,

''(ii) the different categories of family structure covered under the plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

''(iii) changes in benefits or cost-sharing that result in changes the actuarial value of the plan.

''(B) METHODOLOGY.—The Secretary, in consultation with the Secretary of Health and Human Services, shall issue regulations establishing a standard methodology for adjusting a health benefits plan's applicable premiums under subparagraph (A). In the case of any change described in subparagraph (A)(iii), premiums shall be adjusted so that the calculation of the core medical trend rate is made as a comparison between two actuarially equivalent plans.

''(d) LIABILITY FOR PENALTIES.—

''(1) IN GENERAL.—Each coverage provider shall pay the penalty imposed by subsection (a).

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—In the case of a health benefits plan provided under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) OTHER COVERAGE.—In the case of any other health benefits plan, the person that administers the plan benefits.

''(e) EXEMPTIONS.—

''(1) NEW INSURERS AND NEW EMPLOYERS.—This section shall not apply to any health benefits plan which has provided coverage for less than 12 months.

''(2) FIXED INDEMNITY HEALTH COVERAGE PURCHASED WITH AFTER-TAX DOLLARS.—This section shall not apply to any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(3) CERTAIN GOVERNMENT PLANS.—This section shall not apply to the following:

''(A) MEDICARE.—Coverage under part A, part B, part C, or part D of title XVIII of the Social Security Act.

''(B) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1705(a) of such title.

''(4) LOW-COST PLANS.—

''(A) IN GENERAL.—This section shall not apply to any health benefits plan for which the actuarial value for the plan year is not more than the applicable threshold.

''(B) APPLICABLE THRESHOLD.—For purposes of this paragraph, the applicable threshold means the dollar amount which is equal to the actuarial value of the health benefits plan which is at the 10th percentile of actuarial value for all health benefits plans.

''(f) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) HEALTH BENEFITS PLAN.—

''(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and a group health plan.

''(B) GOVERNMENT PLANS INCLUDED.—Such term shall include a plan established and maintained for its civilian employees by the Government of the United States or the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b).

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term under section 5000(b).

''(4) REGULATIONS FOR HEALTH BENEFITS PLANS WITH DIFFERENT PRODUCT LINES.—The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for the combination of product lines of health benefits plans of any health insurance issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess health plan costs determined separately with respect to each product line.

''(5) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan members in their previous group.

''(6) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by this Act, is amended by adding at the end the following new item:

''Sec. 4980I. Excess medical inflation cap.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2012.

SA 2890. Mr. CARPER submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ADVANCE CARE PLANNING.

(a) DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.—

(1) IN GENERAL.—A qualified health plan (as defined in section 1301(a)) shall—

(A) provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in qualified health plans offered through an Exchange;

(B) present such individuals with—

(i) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(ii) information related to other planning tools; and

(C) not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under subparagraph (B) shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(B) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health plan; or

(C) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(3) ADVANCED DIRECTIVE DEFINED.—In this subsection, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

(4) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(A) IN GENERAL.—Subject to subparagraph (C), information provided to meet the requirements of paragraph (1)(B) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed to apply to or affect any option to—

(i) withhold or withdraw of medical treatment or medical care;

(ii) withhold or withdraw of nutrition or hydration; and

(iii) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(C) NO PREEMPTION OF STATE LAW.—Nothing in this subsection shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

(b) VOLUNTARY ADVANCE CARE PLANNING CONSULTATION UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 4103, is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (EE);

(ii) by adding ''and'' at the end of subparagraph (FF); and

(iii) by adding at the end the following new subparagraph:

''(GG) voluntary advance care planning consultation (as defined in subsection (iii)(1));''; and

(B) by adding at the end the following new subsection:

''Voluntary Advance Care Planning Consultation

''(iii)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

''(A) An explanation by the practitioner of advance care planning, including a review of key questions and considerations, advance directives (including living wills and durable powers of attorney) and their uses.

''(B) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(C) An explanation by the practitioner of physician orders regarding life sustaining treatment or similar orders, in States where such orders or similar orders exist.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatments, such as a nurse practitioner or physician assistant).

''(3) An individual may receive the voluntary advance care planning care planning consultation provided for under this subsection no more than once every 5 years unless there is a significant change in the health or health-related condition of the individual.

''(4) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that effectively communicates the individual's preferences regarding life sustaining treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.''.

(2) CONSTRUCTION.—The voluntary advance care planning consultation described in section 1861(iii) of the Social Security Act, as added by paragraph (1), shall be completely optional. Nothing in this subsection shall—

(A) require an individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document;

(B) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title; or

(C) encourage the promotion of suicide or assisted suicide.

(3) PAYMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 4103, is amended by inserting ''(2)(GG),'' after ''assessment),''.

(4) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), as amended by section 4103, is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(Q) in the case of voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(iii)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

SA 2891. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1240, between lines 5 and 6, insert the following:

SEC. 4208. WORKPLACE WELLNESS GRANTS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Beginning in fiscal year 2011, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to eligible small businesses to provide access to comprehensive, evidence-based workplace wellness programs.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a small business shall—

(1) employ less than 100 full or part-time employees; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the wellness program to be carried out using grant funds.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A small business shall use amounts received under a grant under this section to carry out a qualifying wellness program described in paragraph (2).

(2) QUALIFYING WELLNESS PROGRAM.—A qualifying wellness program is described in this paragraph is a program—

(A) under which all employees would be eligible to participate;

(B) that is consistent with evidence-based research and best practices, as determined by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs; and

(C) that includes the following components that have proven to be effective in helping employees make health choices:

(i) Health awareness (such as health education, preventive screenings and health risk assessments).

(ii) Employee engagement (such as mechanisms to encourage employee participation).

(iii) Behavioral change (including elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials).

(iv) Supportive environment (such as creating on-site policies that encourage healthy

lifestyles, healthy eating, physical activity and mental health).

(d) APPROPRIATIONS.—There is authorized to be appropriated, and there is appropriated to carry out this section, $200,000,000 to be used for the 5-fiscal year period beginning with fiscal year 2011.

SA 2892. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1996, between lines 3 and 4, insert the following:

SEC. 9002. CAP ON EXCESS MEDICAL INFLATION.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 4980J. EXCESS MEDICAL COSTS OF HEALTH BENEFITS PLANS.

''(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

''(b) LIMITATION.—No penalty shall be imposed under subsection (a) with respect to a health benefits plan for a plan year if the excess health plan costs of such plan for such year is equal to or less than 0.2 percent.

''(c) EXCESS HEALTH PLAN COSTS.—For purposes of this section—

''(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs' means, with respect to any health benefits plan which has an excess medical inflation rate in excess of 0.2 percent for any year, the product of—

''(A) the applicable premium of such health benefits plan for such year, and

''(B) the excess medical inflation rate for such plan for such year.

''(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan for any year, the amount equal to the excess of—

''(A) the core medical inflation trend rate of such health benefits plan for such year, over

''(B) the medical inflation cap for such year.

''(3) CORE MEDICAL TREND RATE.—The term 'core medical trend rate' means, with respect to any health benefits plan for any year, the amount (expressed as a percentage), if any, by which—

''(A) the actuarially adjusted premium of such plan for such plan for such year, exceeds

''(B) the applicable premium of such plan for the preceding plan year.

''(4) MEDICAL INFLATION CAP.—

''(A) YEARS 2013 TO 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2012 and before 2020, the medical inflation cap shall be the sum of—

''(I) the annualized rate of growth of the gross domestic product for the preceding calendar year (as calculated in the third quarter of the preceding year), plus

''(II) the applicable amount.

''(ii) APPLICABLE AMOUNT.—For purposes of clause (i)(II), the applicable amount shall be determined as follows:

''In the case of a plan year beginning in calendar year—	The applicable amount is—
2013	2.7 percentage points
2014	2.4 percentage points
2015	2.1 percentage points
2016	1.8 percentage points
2017, 2018, or 2019	1.5 percentage points

''(B) YEARS AFTER 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2019, the medical inflation cap shall be equal to the amount (expressed as a percentage), if any, by which—

''(I) the average applicable premium for a low-cost plan for such calendar year, exceeds

''(II) the average applicable premium for a low-cost plan for the preceding calendar year.

''(ii) AVERAGE APPLICABLE PREMIUM FOR A LOW-COST PLAN.—For purposes of this subparagraph, the term 'average applicable premium for a low-cost plan' means the average of the applicable premiums for health benefits plans with applicable premiums below the 33rd percentile, determined by weighting such health benefits plans by the number of individuals enrolled in the plan.

''(d) APPLICABLE PREMIUM; ACTUARIALLY ADJUSTED PREMIUM.—For purposes of this section—

''(1) APPLICABLE PREMIUM.—The term 'applicable premium' has the meaning given such term under section 4980B(f)(4).

''(2) ACTUARIALLY ADJUSTED PREMIUM.—

''(A) IN GENERAL.—The term 'actuarially adjusted premium' means, for any health benefits plan for any year, the applicable premium for such year adjusted, according to actuarial standards and the method prescribed by the Secretary under subparagraph (B), by excluding any cost attributable to—

''(i) the attributes of individuals (such as age, gender, and health risk measures) covered under the plan,

''(ii) the different categories of family structure covered under the plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

''(iii) changes in benefits or cost-sharing that result in changes the actuarial value of the plan.

''(B) METHODOLOGY.—The Secretary, in consultation with the Secretary of Health and Human Services, shall issue regulations establishing a standard methodology for adjusting a health benefits plan's applicable premiums under subparagraph (A). In the case of any change described in subparagraph (A)(iii), premiums shall be adjusted so that the calculation of the core medical trend rate is made as a comparison between two actuarially equivalent plans.

''(e) LIABILITY FOR PENALTIES.—

''(1) IN GENERAL.—Each coverage provider shall pay the penalty imposed by subsection (a).

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—In the case of a health benefits plan provided under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) OTHER COVERAGE.—In the case of any other health benefits plan, the person that administers the plan benefits.

''(f) EXEMPTIONS.—

''(1) NEW INSURERS AND NEW EMPLOYERS.—This section shall not apply to any health benefits plan which has provided coverage for less than 12 months.

''(2) FIXED INDEMNITY HEALTH COVERAGE PURCHASED WITH AFTER-TAX DOLLARS.—This section shall not apply to any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(3) CERTAIN GOVERNMENT PLANS.—This section shall not apply to the following:

''(A) MEDICARE.—Coverage under part A, part B, part C, or part D of title XVIII of the Social Security Act.

''(B) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1705(a) of such title.

''(4) LOW-COST PLANS.—

''(A) IN GENERAL.—This section shall not apply to any health benefits plan for which the actuarial value for the plan year is not more than the applicable threshold.

''(B) APPLICABLE THRESHOLD.—For purposes of this paragraph, the applicable threshold means the dollar amount which is equal to the actuarial value of the health benefits plan which is at the 10th percentile of actuarial value for all health benefits plans.

''(g) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) HEALTH BENEFITS PLAN.—

''(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and a group health plan.

''(B) GOVERNMENT PLANS INCLUDED.—Such term shall include a plan established and maintained for its civilian employees by the Government of the United States or the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b).

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term under section 5000(b).

''(4) REGULATIONS FOR HEALTH BENEFITS PLANS WITH DIFFERENT PRODUCT LINES.—The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for the combination of product lines of health benefits plans of any health insurance issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess health plan costs determined separately with respect to each product line.

''(5) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan members in their previous group.

''(6) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by this Act, is amended by adding at the end the following new item:

''Sec. 4980J. Excess medical inflation cap.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2012.

SA 2893. Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

SEC. 3211. IMPROVEMENTS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p) of the Social Security Act, as added by section 3201, is amended—

(1) in paragraph (3)—

(A) by redesignating subparagraph (C) as subparagraph (D);

(B) in subparagraph (D), as so redesignated, by striking ''(A) or (B)'' and inserting ''(A), (B), or (C)''; and

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C) A county where the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for the year is greater than 45 percent (as determined by the Secretary).''; and

(2) in paragraph (5), by striking ''$5,000,000,000'' and inserting ''$7,500,000,000''.

SA 2894. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 938, strike lines 17, 18, and 19 and insert the following:

''(A) IN GENERAL.—The term 'discounted price' means—

''(i) in the case of an applicable drug that is a biologic product, 75 percent of the negotiated price of the applicable drug of the manufacturer; and

''(ii) in the case of any other applicable drug, 50 percent of the negotiated price of the applicable drug of the manufacturer.

SA 2895. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1906, between lines 5 and 6, insert the following:

(i) BIOLOGICAL PRODUCT EXCLUSIVITY PERIOD.—

(1) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Section 351 of the Public Health Service Act (as amended by subsections (a) and (g)), is further amended—

(A) in subsection (k)(7), by striking subparagraph (A) and inserting the following:

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—

''(i) IN GENERAL.—Approval of an application under this subsection may not be made effective by the Secretary until the earlier of—

''(I) the date that is 12 years after the date on which the reference product was first licensed under subsection (a); or

''(II) the date on which the Secretary determines that the gross sales in the United States of the reference product equals or exceeds $3,500,000,000.

''(ii) ANNUAL REPORTING.—As a condition for receiving the period of exclusivity described in clause (i), a person who receives a license for a biological product under subsection (a) shall, not later than January 31 of each year, report to the Secretary the amount of the annual gross sales in the United States in the preceding calendar year for such biological product.''; and

(B) in subsection (m)(2)(A), by striking ''12 years and 6 months rather than 12 years'' and inserting ''the date that is 6 months after the date described in subsection (k)(7)(A)(i) rather than the date described in such subsection.''.

(2) CONFORMING AMENDMENT.—Section 7002(h)(2) of this Act is amended by striking ''the 12-year period described in subsection (k)(7) of such section 351'' and inserting ''the period of exclusivity described in subsection (k)(7)(A)(i) of such section 351''.

SA 2896. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 128, between lines 6 and 7, insert the following:

(e) MEDICAL LOSS RATIO.—The Secretary shall develop a definition for the term ''medical loss ratio'', and provide standards for such term, including methods for calculating loss ratios and determinations of what constitutes an administrative cost.

SEC. 1305. HEALTH INSURANCE REPORT CARDS.

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary shall develop a standardized health insurance report card.

(b) STANDARDS.—The report card described in subsection (a) shall provide measures of the performance of qualified health plans with regard to—

(1) the adequacy of the provider network;

(2) the timeliness and accuracy of payment of claims, measured with regard to claims overall and claims associated with selected health conditions and medical services;

(3) appeals and grievance procedures;

(4) adherence to fair marketing practices;

(5) satisfaction of minimum medical loss ratios;

(6) non-discrimination on the basis of health status;

(7) quality measures, as determined by the Secretary;

(8) renewal rate increases; and

(9) other factors, as the Secretary determines appropriate.

(c) DATA COLLECTION.—The Secretary shall, in cooperation with State insurance regulators, collect data for the purpose of determining the performance of qualified health plans with regard to the standards described in subsection (b).

(d) REPORT CARDS.—The data collected under subsection (c) shall be compiled into a standardized health insurance report card, described in subsection (a), and shall be made available to consumers for the purpose of facilitating health plan comparison and choice, including by making such report cards available through the Internet portal established under section 1103(a).

(e) USE OF HEALTH PLAN REPORT CARDS BY THE SECRETARY.—The Secretary—

(1) may use the data collected under subsection (c) for administrative purposes;

(2) shall use such data to determine unreasonable increases in premiums for health insurance coverage, which may trigger action by the Secretary, such as imposing premium rebates or other sanctions, as appropriate; and

(3) may share such data with State insurance regulators, the Secretary of the Treasury, and the Secretary of Labor, for purposes of oversight and enforcement of the requirements under this title, including sharing such data with administrators of the Exchanges and using such data in negotiations with health insurance issuers over the terms of participation in such Exchanges.

SA 2897. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1529, between lines 2 and 3, insert the following:

SEC. 1572. INCREASED FUNDING FOR WORKFORCE PROGRAMS; LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

(a) LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.—

(1) IN GENERAL.—Section 274 of the Internal Revenue Code of 1986 (relating to disallowance of certain entertainment, etc., expenses) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.—The amount allowable as a deduction under this chapter for expenses relating to direct to consumer advertising in any media of prescription pharmaceuticals shall not exceed 30 percent of the amount of such expenses which would (but for this paragraph) be allowable as a deduction under this chapter.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred after December 31, 2009, in taxable years ending after such date.

(b) HEALTH PROFESSIONALS TRAINING FOR DIVERSITY.—Section 740(a) of the Public Health Service Act, as amended by section 5402, is further amended by striking ''$51,000,000'' and inserting ''$100,000,000''.

(c) TEACHING HEALTH CENTERS.—Section 340H(g) of the Public Health Service Act, as added by section 5508, is amended by striking ''$230,000,000'' and inserting ''$460,000,000''.

(d) NATIONAL HEALTH SERVICE CORPS.—Section 338H of the Public Health Service Act, as amended by section 5207, is further amended by striking ''$320,461,632'' and inserting ''$600,000,000''.

(e) PRIMARY CARE TRAINING AND ENHANCEMENT.—Section 747 of the Public Health Service Act, as amended by section 5301, is further amended by striking ''$125,000,000'' and inserting ''$250,000,000''.

(f) TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.—Section 748 of the Public Health Service Act, as added by section 5303, is amended by striking ''$30,000,000'' and inserting ''$60,000,000''.

(g) PRIMARY CARE EXTENSION PROGRAM.—Section 399W(f) of the Public Health Service Act, as added by section 5405, is amended by striking ''$120,000,000'' and inserting ''$240,000,000''.

SA 2898. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Additional Health Care Quality and Efficiency Improvements

SEC. 3601. REPORT ON DEMONSTRATION AND PILOT PROGRAMS.

(a) REPORT.—Not later than 12 months after the date of enactment of this Act, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a report that describes all pilot programs and demonstration projects that the Secretary has authority to carry out (regardless of whether such programs or projects are actually implemented), as authorized by law, during the period for which the report is submitted.

(b) REQUIREMENTS.—A report under subsection (a) shall—

(1) list all pilot programs or demonstration projects involved and indicate whether each program or project is—

(A) not yet being implemented;

(B) currently being implemented; or

(C) complete and awaiting further determinations; and

(2) with respect to programs or projects described in subparagraphs (A) or (B) of paragraph (1), include the recommendations of the Secretary as to whether such programs or projects are necessary.

(c) ACTIONS BASED ON RECOMMENDATIONS.—Based on the recommendations of the Secretary under subsection (b)(2)—

(1) if the Secretary determines that a program or project is necessary, the Secretary shall submit to Congress a strategic plan for the implementation of the program or project and may transfer such program or project into the jurisdiction of the Innovation Center of the Centers for Medicare & Medicaid Services; or

(2) if the Secretary determines that a program or project is unnecessary, the Secretary may terminate the program.

(d) ACTION BY CONGRESS.—Congress may continue in effect any program or project terminated by the Secretary under subsection (c)(2) through the enactment of a Concurrent Resolution expressing the sense of Congress to continue the program or project involved.

SEC. 3602. AVAILABILITY OF DATA ON DENIAL OF CLAIMS.

Section 2715(b)(3) of the Public Health Service Act, as added by section 1001, is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) by redesignating subparagraph (I) as subparagraph (J): and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) a statement relating to claims procedures including the percentage of claims that are annually denied by the plan or coverage and the percentage of such denials that are overturned on appeal; and''.

SEC. 3603. ACCELERATION AND INCREASE OF THE PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

Section 1886(p) of the Social Security Act (42 U.S.C. 1395(p)), as added by section 3008(a), is amended—

(1) in paragraph (1)—

(A) by striking ''2015'' and inserting ''2013''; and

(B) by striking ''99 percent'' and inserting ''98 percent''; and

(2) in paragraph (5), by striking ''2015'' and inserting ''2013''.

SEC. 3604. IMPROVEMENTS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in subsection (a)(3), by striking ''January 1, 2013'' and inserting ''January 1, 2012''; and

(2) by amending subsection (g) to read as follows:

''(g) AUTHORITY TO EXPAND IMPLEMENTATION.—

''(1) IN GENERAL.—Taking into account the evaluation under subparagraph (e), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of the pilot program, to the extent determined appropriate by the Secretary, if—

''(A) the Secretary determines that such expansion is expected to—

''(i) reduce spending under this title without reducing the quality of care; or

''(ii) improve the quality of care and reduce spending; and

''(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this title.

''(2) IMPLEMENTATION PLAN.—In the case where the Secretary does not exercise the authority under paragraph (1) by January 1, 2015, not later than such date, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.''.

SEC. 3605. ENCOURAGING MEDICARE BENEFICIARIES TO CHOOSE HIGH PERFORMING PROVIDERS.

(a) AUTHORIZATION TO ESTABLISH A PILOT PROGRAM TO ENCOURAGE CHOICE OF HIGH PERFORMING PROVIDERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may establish a pilot program under which Medicare beneficiaries are encouraged to choose high performing providers under the Medicare program under title XVIII of the Social Security Act.

(2) CONSIDERATION OF MEDICARE VALUE-BASED PURCHASING REFORMS.—If the Secretary establishes a pilot program under paragraph (1), the Secretary shall, as the Secretary determines appropriate, take into consideration information obtained under value-based purchasing reforms implemented under the Medicare program, including such reforms under the provisions of and amendments made by this Act, in establishing such pilot program.

(b) DEVELOPMENT OF PHYSICIAN COMPARE INTERNET WEBSITE.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website for use by Medicare beneficiaries to access quality and utilization data with respect to physicians (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) participating in the Medicare program.

(2) INFORMATION AVAILABLE.—Information shall be made available on such Internet website on an ongoing basis as follows:

(A) Not later than January 1, 2011 (and for each subsequent year before 2015), the Internet website shall include information regarding which physicians received an incentive payment for quality reporting under section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) of the Social Security Act for the preceding year (and, beginning with 2015, which physicians received an incentive payment adjustment under section 1848(a)(8) of such Act, as added by section 3002(b) for the year).

(B) On or after January 1, 2013, the Internet website may, as determined appropriate by the Secretary, include information on the utilization rates of physicians, as determined for purposes of section 1848(a)(9) of such Act, as added by section 3003.

(C) On or after January 1, 2014, the Internet website may, as determined appropriate by the Secretary, include information on quality measures selected by the Secretary, in consultation with the Physician Payment Advisory Committee, from among measures reported under the physician reporting system under section 1848(k) of such Act (42 U.S.C. 1395w–4(k)).

(D) On or after January 1, 2017, the Internet website shall include results of the application of the value-based payment modifier established under section 1848(p) of the Social Security Act, as added by section 3007, together with the results of any similar provisions under title XVIII of such Act, in order for Medicare beneficiaries to see how the quality and cost of services furnished by physicians compares to the quality and cost of services furnished by their peers. Such information should, if the Secretary determines appropriate, identify physicians performing in the top 50, 60, 70, and 80th percentiles as compared to their peers.

(3) REPORT TO CONGRESS.—Not later than January 1, 2019, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under this subsection, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) EXPANSION.—At any time before the date on which the report is submitted under paragraph (3), the Secretary may expand (including expansion to other providers of services and suppliers under part B of title XVIII of the Social Security Act) the information made available on such website if the Secretary determines such expansion would improve the quality of care and reduce spending under such title.

(c) PROVIDING FINANCIAL INCENTIVES TO BENEFICIARIES UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.—Section 1115A(b)(2)(B) of the Social Security Act, as added by section 3021, is amended by adding at the end the following new clause:

''(xix) Effective beginning on or after January 1, 2018, providing financial incentives to Medicare beneficiaries who are furnished services by high performing physicians, as determined by the Secretary, taking into consideration information made available on the Physician Compare Internet website developed under section 3009(b) of the Patient Protection and Affordable Care Act.''.

SA 2899. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

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

SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, insert the following:

SEC. 5316. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING PROGRAMS.

(a) IN GENERAL.—Section 768 of the Public Health Service Act (42 U.S.C. 295c) is amended to read as follows:

''SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private nonprofit hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

(b) REAUTHORIZATION.—Section 770(a) of the Public Health Service Act (42 U.S.C. 295e(a)) is amended to read as follows:

''(a) IN GENERAL.—For the purpose of carrying out this subpart, there is authorized to be appropriated $43,000,000 for fiscal year 2011, and such sums as may be necessary for each of the fiscal years 2012 through 2015.''.

SA 2901. Mr. THUNE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

SA 2902. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

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

SA 2903. Ms. SNOWE (for herself, Mr. DURBIN, Mr. MERKLEY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 126, strike lines 10 through 16.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 167, strike lines 1 through 4, and insert the following:

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(2) EXCEPTION FOR SMALL EMPLOYER MANDATES.—The provisions of, and the amendments made by, this title shall preempt any State law enacted after the date of enactment of this Act that would impose a requirement on any employer with less than 50 full-time employees to, or would impose a penalty on such an employer for failing to, offer health insurance to its employees.

SA 2905. Mrs. LINCOLN (for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

On page 2040, strike line 14 and insert the following:

(b) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—

(1) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(I) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—In the case of a taxable year in which the $500,000 amount in clauses (i) and (ii) of subparagraph (A) exceeds the dollar amount of the compensation received by the President under section 102 of title 3, United States Code, for such taxable year, such clauses shall be applied by substituting the dollar amount provided in such section 102 for such $500,000 amount.''.

(2) REVENUE INCREASE TO BE TRANSFERRED TO MEDICARE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended—

(A) by striking ''and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ''; and'', and

(C) by inserting after paragraph (2) the following new paragraph:

''(3) the revenues resulting from the application of section 162(m)(6) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Secretary's delegate.''.

(c) EFFECTIVE DATE.—The amendments made by

SA 2906. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 308, line 16, strike all through page 314, line 6, and insert the following:

''(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—

''(1) IN GENERAL.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but

not below zero) by the sum of the following amounts:

''(A) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 40.

''(B) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

''(2) SAFEHARBOR FOR GROWING EMPLOYERS.—

''(A) IN GENERAL.—Notwithstanding paragraph (1) and except as provided in subparagraph (B), the amount of the credit determined under subsection (b) for any taxpayer for the second or third taxable year of the credit period for such taxpayer shall not be reduced by an amount greater than the amount by which it would be reduced if such reduction amount were determined by using the same fractions determined under paragraph (1) for the first taxable year of such credit period.

''(B) REDUCTION IN AGGREGATE AMOUNT OF CONTRIBUTIONS.—For purposes of determining the amount of the credit under subsection (b) for any taxpayer to whom subparagraph (A) applies for any taxable year of the taxpayer in the credit period after the first such taxable year, the amount of the nonelective contributions made on behalf of any employee whose annual wages exceed twice the dollar amount in effect under subsection (d)(3)(B) for such taxable year which may be taken into account under subsection (b) shall not exceed such annual wages multiplied by a fraction the numerator of which is twice the dollar amount so in effect and the denominator of which is such annual wages.

''(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—

''(A) which has no more than 50 full-time equivalent employees for the taxable year,

''(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

''(C) which has in effect an arrangement described in paragraph (4).

Notwithstanding subparagraphs (A) and (B), an employer which is an eligible small employer for the first taxable year in a credit period shall be treated as an eligible small employer for the remaining taxable years in such credit period.

''(2) FULL-TIME EQUIVALENT EMPLOYEES.—

''(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—

''(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

''(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

''(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

''(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(3) AVERAGE ANNUAL WAGES.—

''(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

''(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

''(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

''(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $25,000.

''(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

''(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

''(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

''(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

''(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE.—

''(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

''(i) an employee within the meaning of section 401(c)(1),

''(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

''(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

''(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

''(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 3-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

SA 2907. Ms. KLOBUCHAR (for herself, Mr. THUNE, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 828, between lines 3 and 4, insert the following:

SEC. 3130. REMOTE MONITORING PILOT PROJECTS.

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct pilot projects under title XVIII of the Social Security Act for the purpose of providing incentives to home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health outcomes for medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 1 of the pilot projects in a State with a population of less than 1,000,000.

(3) DEFINITION OF HOME HEALTH AGENCY.—In this section, the term ''home health agency'' has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act for medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the medicare savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the Secretary may initiate comparable projects in additional areas.

(g) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SA 2908. Ms. KLOBUCHAR (for herself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 492, between lines 15 and 16, insert the following:

SEC. 2407. SUPPORT FOR FAMILY CAREGIVERS UNDER MEDICARE AND MEDICAID.

(a) MEDICARE FAMILY CAREGIVER INFORMATION AND REFERRAL.—State health insurance assistance programs, the Administrator of the Centers for Medicare & Medicaid Services, and the Assistant Secretary of the Administration on Aging shall, in collaboration with each other, directly or by contract, develop practical, easy-to-understand information and referral protocols for health care providers, social workers, and other appropriate individuals to provide to family caregivers of Medicare beneficiaries either on admission to or discharge from a hospital (including a discharge from a hospital emergency room or a hospital outpatient department which has furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)), a comprehensive rehabilitation facility (as defined in section 1861(cc)(2) of such Act (42 U.S.C. 1395x(cc)(2)) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o)). Information developed under the preceding sentence shall—

(1) include information on national, State, and community-based resources for seniors, individuals with disabilities and their caregivers, which shall be updated on a semi-annual basis (or as frequently as practicable);

(2) be disseminated by health care providers, social workers, and other appropriate individuals as printed materials (including materials in Spanish and other languages (other than English) as appropriate); and

(3) be made available on the Internet websites of State health insurance assistance programs, the Centers for Medicare & Medicaid Services, and the Administration on Aging.

(b) MEDICAID ASSESSMENT OF FAMILY CAREGIVER SUPPORT NEEDS.—

(1) IN GENERAL.—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 2401, is amended—

(A) in subsection (c)(2)—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(F) under such waiver the State may provide for an assessment of family caregiver support needs (in accordance with subsection (l)).'';

(B) in subsection (d)(2)—

(i) in subparagraph (B), by striking ''and'' at the end;

(ii) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(D) under such waiver the State may provide for an assessment of family caregiver support needs (in accordance with subsection (l)).'';

(C) in subsection (i)(1)(F), by adding at the end the following new clause:

''(vii) Where appropriate, an assessment of family caregiver support needs (in accordance with subsection (l)).''; and

(D) by adding at the end the following new subsection:

''(l) ASSESSMENT OF FAMILY CAREGIVER SUPPORT NEEDS.—

''(1) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services under a waiver under subsection (c) or (d) or under section 1115, under a State plan amendment under subsection (i), under an MFP demonstration project established under section 6071 of the Deficit Reduction Act of 2005, or as part of self-directed personal assistance services provided pursuant to a written plan of care in accordance with the requirements of subsection (j), and who is dependent upon the assistance of a family caregiver, the State may provide for an assessment of the family caregiver support needs of the individual. Such assessment shall, to the extent feasible, be conducted at the same time as, or closely coordinated with, the determination of the eligibility of the individual for such services.

''(2) QUESTIONNAIRE.—

''(A) IN GENERAL.—Such assessment shall include asking the family caregiver of the individual questions in order to determine whether they would benefit from targeted support services (such as those services described in paragraph (3)).

''(B) COMPLETION ON A VOLUNTARY BASIS.—The answering of questions under subparagraph (A) by a family caregiver shall be on a voluntary basis.

''(3) TARGETED SUPPORT SERVICES DESCRIBED.—The following targeted support services are described in this paragraph:

''(A) Respite care and emergency back-up services (including short-term help for the individual that gives the family caregiver a break from providing such care).

''(B) Individual counseling (including advice and consultation sessions to bolster emotional support for the family caregiver to make well-informed decisions about how to cope with the strain of supporting the individual).

''(C) Support groups, including groups which provide help for family caregivers to—

''(i) locate a support group either locally or online to share experiences and reduce isolation;

''(ii) make well-informed decisions about caring for the individual; and

''(iii) reduce isolation.

''(D) Information and assistance (including brochures and online resources for researching a disease or disability or learning and managing a regular caregiving role, new technologies that can assist family caregivers, and practical assistance for locating services).

''(E) Chore services (such as house cleaning).

''(F) Personal care (including outside help).

''(G) Education and training (including workshops and other resources available with information about stress management, self-care to maintain good physical and mental health, understanding and communicating with individuals with dementia, medication management, normal aging processes, change in disease and disability, the role of assistive technologies, and other relevant topics).

''(H) Legal and financial planning and consultation (including advice and counseling regarding long-term care planning, estate planning, powers of attorney, community property laws, tax advice, employment leave advice, advance directives, and end-of-life care).

''(I) Transportation (including transportation to medical appointments).

''(J) Other targeted support services the Secretary or the State determines appropriate.

''(4) REFERRALS.—In the case where a questionnaire completed by a family caregiver under paragraph (2) indicates that the family caregiver would benefit from 1 or more of the targeted support services described in paragraph (3), the State shall provide referrals to the family caregiver for local, State, and private-sector family caregiver programs and other resources that provide such targeted support services.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to medical assistance for home and community-based services that is provided on or after the date of enactment of this Act.

SA 2909. Mr. NELSON of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees,

and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1449, strike line 1 and all that follows through page 1458, line 5, and insert the following:

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)''; and

(3) by adding at the end the following new paragraph:

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) ADDITIONAL RESIDENCY POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had residency positions that were unused for all 5 of the most recent cost reporting periods ending prior to the date of enactment of this paragraph by an amount that is equal to the number of such unused residency positions.

''(II) EXCEPTION FOR RURAL HOSPITALS AND CERTAIN OTHER HOSPITALS.—This subparagraph shall not apply to a hospital—

''(aa) located in a rural area (as defined in subsection (d)(2)(D)(ii));

''(bb) that has participated in a voluntary reduction plan under paragraph (6); or

''(cc) that has participated in a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248.

''(ii) NUMBER AVAILABLE FOR DISTRIBUTION.—The number of additional residency positions available for distribution under subparagraph (B) shall be an amount that the Secretary determines would result in a 15 percent increase in the aggregate number of full-time equivalent residents in approved medical training programs (as determined based on the most recent cost reports available at the time of distribution). One-third of such number shall only be available for distribution to hospitals described in subclause (I) of subparagraph (B)(ii) under such subparagraph.

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after the date of enactment of this paragraph. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the number of additional residency positions available for distribution under subparagraph (A)(ii).

''(ii) DISTRIBUTION TO HOSPITALS ALREADY OPERATING OVER RESIDENT LIMIT.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital in which the reference resident level of the hospital (as specified in clause (iii)) is greater than the otherwise applicable resident limit, the increase in the otherwise applicable resident limit under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

''(aa) the number of resident positions by which the reference resident level of the hospital exceeds the otherwise applicable resident limit for the hospital; and

''(bb) the number of resident positions by which the reference resident level of all such hospitals with respect to which an application is approved under this subparagraph exceeds the otherwise applicable resident limit for such hospitals.

''(II) REQUIREMENTS.—A hospital described in subclause (I)—

''(aa) is not eligible for an increase in the otherwise applicable resident limit under this subparagraph unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery (as of the date of enactment of this paragraph); and

''(bb) shall continue to train at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery for the 10-year period beginning on such date.

In the case where the Secretary determines that a hospital no longer meets the requirement of item (bb), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this clause.

''(III) CLARIFICATION REGARDING ELIGIBILITY FOR OTHER ADDITIONAL RESIDENCY POSITIONS.—Nothing in this clause shall be construed as preventing a hospital described in subclause (I) from applying for additional residency positions under this paragraph that are not reserved for distribution under this clause.

''(iii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in subclause (II), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before the date of enactment of this paragraph, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAM OR ESTABLISHMENT OF NEW PROGRAM.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program or the establishment of a new residency training program that is not reflected on the most recent cost report that has been settled (or, if not, submitted (subject to audit)), subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2010, made available under this paragraph, as determined by the Secretary.

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall distribute the increase to hospitals based on the following criteria:

''(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions. In the case of any increase based on such preference, a hospital shall ensure that—

''(I) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position is filled; and

''(II) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirement of subclause (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph.

''(ii) The Secretary shall give preference to hospitals that emphasize training in community health centers and other community-based clinical settings.

''(iii) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios). In determining the number of medical students in a State for purposes of the preceding sentence, the Secretary shall include planned students at medical schools which have provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association.

''(iv) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(E) LIMITATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(III)) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

''(ii) INCREASE IN NUMBER OF ADDITIONAL POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

''(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(G) DISTRIBUTION.—The Secretary shall distribute the increase to hospitals under this paragraph not later than 2 years after the date of enactment of this paragraph.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this

subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SA 2910. Mr. FRANKEN (for himself, Mr. ROCKEFELLER, Mrs. LINCOLN, Mr. WHITEHOUSE, Mr. LEAHY, Mr. SANDERS, Mr. BROWN, and Mr. BEGICH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 1003, insert the following:

SEC. 1004. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

(a) IN GENERAL.—Section 2718 of the Public Health Service Act, as added by section 1001, is amended to read as follows:

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

''(a) CLEAR ACCOUNTING FOR COSTS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the plan or issuer on activities described in subsection (a)(3) exceeds 10 percent, or such lower percentage as a State may by regulation determine.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by group health plans and health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

''(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

''(d) DEFINITIONS.—Not later than December 31, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities.''.

(b) TECHNICAL AMENDMENTS.—

(1) ERISA.—Section 715(b) of the Employee Retirement Income Security Act, as amended by section 1562(e), is further amended by striking ''sections 2716 and 2718'' and inserting ''section 2716''.

(2) IRC.—Section 9815(b) of the Internal Revenue Code of 1986 is amended by striking ''sections 2716 and 2718'' and inserting ''section 2716''.

SA 2911. Mr. FRANKEN (for himself and Mr. LUGAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, insert the following:

SEC. 4208. NATIONAL DIABETES PREVENTION PROGRAM.

Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 5405, is further amended by adding at the end the following:

''SEC. 399V–2. NATIONAL DIABETES PREVENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the 'program') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

''(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

''(1) a grant program for community-based diabetes prevention program model sites;

''(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

''(3) a training and outreach program for lifestyle intervention instructors; and

''(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

''(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SA 2912. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ___. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

Section 340E(g)(2) of the Public Health Service Act (42 U.S.C. 256e(g)) is amended—

(1) by striking ''means a'' and inserting ''means—

''(A) a'';

(2) by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(B) a freestanding psychiatric hospital with 90 percent or more inpatients under the age of 18, that has its own Medicare provider number as of December 6, 1999, and that has an accredited residency program.''.

SA 2913. Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

SEC. 5510. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

Subpart IX of part D of title III of the Public Health Service Act (42 U.S.C. 256e et seq.) is amended—

(1) in the subpart heading, by adding ''**and Women's Hospitals**'' at the end; and

(2) by adding at the end the following:

''SEC. 340E-1. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

''(a) PAYMENTS.—The Secretary shall make two payments under this section to each women's hospital for each of fiscal years 2010 through 2014, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amounts payable under this section to a women's hospital for an approved graduate medical residency training program for a fiscal year shall be each of the following:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for direct expenses associated with operating approved graduate medical residency training programs for a fiscal year.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs for a fiscal year.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to women's hospitals under

paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the funds appropriated under subsection (e) for such payments for that fiscal year.

''(B) PRO RATA REDUCTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (e) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1)(A), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(3) ANNUAL REPORTING REQUIRED.—The provisions of subsection (b)(3) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(d) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 12 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed Medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established. In the case of a hospital that does not report residents on a Medicare cost report, such interim payments shall be based on the number of residents trained during the hospital's most recently completed Medicare cost report filing period.

''(2) WITHHOLDING.—The Secretary shall withhold up to 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1) as necessary to ensure a hospital will not be overpaid on an interim basis.

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made and pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1886(d) of such Act is subject to review under such section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $12,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(f) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A) of the Social Security Act.

''(2) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.

''(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means a hospital—

''(A) that has a Medicare provider agreement under title XVIII of the Social Security Act;

''(B) that has an approved graduate medical residency training program;

''(C) that has not been excluded from the Medicare prospective payment system;

''(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

''(E) with respect to which and as determined by the Centers for Medicare & Medicaid Services, less than 4 percent of the total discharges from the hospital during 2007 were Medicare discharges of individuals who, as of the time of the discharge—

''(i) were enrolled in the original Medicare fee-for-service program under part A of title XVIII of the Social Security Act; and

''(ii) were not enrolled in—

''(I) a Medicare Advantage plan under part C of title XVIII of that Act;

''(II) an eligible organization under section 1876 of that Act; or

''(III) a PACE program under section 1894 of that Act.''.

SA 2914. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2029, between lines 4 and 5, insert the following:

(c) PERFORMANCE ADJUSTMENT TO ANNUAL FEE.—

(1) IN GENERAL.—The Secretary shall—

(A) in the case of a penalized covered entity, increase the fee determined under subsection (b) for a calendar year as provided in paragraph (3), and

(B) in the case of any other covered entity, reduce the fee determined under subsection (b) for a calendar year as provided in paragraph (4).

(2) PENALIZED COVERED ENTITY DESCRIBED.—

(A) IN GENERAL.—For purposes of this paragraph, the term ''penalized covered entity'' means a covered entity that the Secretary determines has failed to meet the key performance thresholds (established under subparagraph (B)) for the calendar year involved.

(B) KEY PERFORMANCE THRESHOLDS.—The key performance thresholds established under this subparagraph are as follows:

(i) MEDICAL LOSS RATIO THRESHOLD.—The covered entity has a medical loss ratio, as reported under section 2718(a)(1) of the Public Health Service Act, of not less than 85 percent. The Secretary, in consultation with the Secretary of Health and Human Services may increase, but not decrease, such percentage by regulation.

(ii) MAXIMUM FINANCIAL RESERVE THRESHOLD.—

(I) IN GENERAL.—The covered entity has a financial reserve which is not greater than the amount established under regulations by the Secretary, in consultation with the Secretary of Health and Human Services. The Secretary may establish different thresholds for different categories of covered entity under this section. The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish a uniform methodology for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

(II) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulation) to the Secretary and the Secretary of Health and Human Services containing such information about the financial reserves of the entity as the Secretary may require. The rules of subsection (g)(2) shall apply to the information required to be reported under this subclause.

(3) AMOUNT OF FEE INCREASE.—

(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be increased by the penalty amount.

(B) PENALTY AMOUNT.—

(i) IN GENERAL.—The penalty amount shall be the product of—

(I) the amount determined under subsection (b), and

(II) the sum of the amounts determined under subparagraphs (C) and (D).

(ii) LIMITATION.—The penalty amount shall not exceed 20 percent of the amount determined under subsection (b).

(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio threshold established under paragraph (2)(A), over

(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the financial reserves of the penalized covered entity, over

(II) the maximum financial reserve threshold established under paragraph (2)(B)(ii), to

(ii) such maximum financial reserve threshold.

(4) REDUCTION IN FEE.—

(A) IN GENERAL.—

(i) AMOUNT OF REDUCTION.—In the case of any covered entity that is not a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be reduced by an amount equal to the product of—

(I) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

(II) the fee redistribution ratio.

(ii) LIMITATION.—The reduction under this paragraph shall not exceed 20 percent of the amount determined under subsection (b).

(B) FEE DISTRIBUTION RATIO.—For purposes of this paragraph, the fee redistribution ratio is the ratio of—

(i) the weighted net written premium amount of the covered entity, to

(ii) the aggregate of the weighted net written premium amount of all covered entities.

(C) WEIGHTED NET WRITTEN PREMIUM AMOUNT.—For purposes of this paragraph, the weighted net written premium amount with respect to any covered entity is the amount described in subsection (b)(1)(A)(i) with respect to such covered entity, increased by the product of—

(i) such amount, and

(ii) the product of 0.05 and the sum of the amounts determined under subparagraphs (D) and (E).

(D) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio (expressed as a percentage) of the covered entity, over

(ii) the medical loss ratio threshold established under paragraph (2)(A).

(E) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the maximum financial reserve threshold established under paragraph (2)(B)(ii), over

(II) the financial reserves of the covered entity, to

(ii) such maximum financial reserve threshold.

SA 2915. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 531, line 2, insert the following after the period: ''In awarding planning grants, the Secretary shall give preference to States that agree to develop a State plan amendment that includes methodologies and procedures that are intended to improve coordination of care for eligible individuals with chronic conditions who are high users of health care services (including emergency room and inpatient hospital services), including through the use of referrals to health homes and outreach care management services.''

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1539, line 7, insert ''in a rural area (as defined in section 1886(d)(2)(D)), a medically underserved community (as defined in section 799B(6) of the Public Health Service Act), or'' after ''located''.

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 116, between lines 6 and 7, insert the following:

(4) SPECIAL RULE REGARDING PREGNANCY.—An individual who becomes pregnant and is enrolled in a catastrophic plan described under this subsection may, notwithstanding any other provision of law, enroll in another qualified health plan during such individual's pregnancy.

SA 2918. Mr. MENENDEZ (for himself, Ms. STABENOW, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 116, between lines 13 and 14, insert the following:

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 33, strike line 5 and all that follows through line 4 on page 34 and insert the following:

''SEC. 2719. APPEALS PROCESS.

''(a) INTERNAL CLAIMS APPEALS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

''(1) have in effect an internal claims appeal process;

''(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

''(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

''(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

''(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

''(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

''(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

''(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).''.

SA 2920. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 1103, insert the following:

SEC. 1104. REPORTING REQUIREMENTS REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS.

(a) REQUIREMENTS REGARDING DENIAL OF COVERAGE FOR MEDICAL SERVICES.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate regulations requiring health insurance issuers to report annually to the Secretary data concerning—

(A) each denial of coverage for medical services to a plan enrollee in the preceding year, listed by the types of services for which coverage was denied; and

(B) the reasons such coverage was denied.

(2) PUBLICATION OF DATA.—The Secretary shall make the data reported under paragraph (1) available to the public on the Internet website described in section 1103(a).

(b) REQUIREMENTS REGARDING DENIAL OF ENROLLMENT IN A HEALTH INSURANCE PLAN.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary shall issue regulations requiring each health insurance issuer to report annually to the Secretary data concerning—

(A) each incident in which such issuer, in the preceding year, denied the application of an individual to enroll in a health insurance plan offered by such issuer; and

(B) the reasons each such application was denied.

(2) PUBLICATION OF DATA.—The Secretary shall make the data reported under paragraph (1) available to the public on the Internet website described in section 1103(a).

(3) SUNSET.—The requirements under this subsection shall cease to have effect on January 1, 2014.

(c) CONSULTATION.—In developing the regulations under subsection (a)(1) and (b)(1) and collecting data as required by such subsections, the Secretary shall consult with State insurance commissioners and the National Association of Insurance Commissioners.

(d) APPLICABILITY OF REQUIREMENTS.—The reporting requirements under this section shall apply to all health insurance issuers and all health insurance plans, without regard to whether such issuer offers a qualified health plan, or whether such plan is a qualified health plan, as described in subtitle D.

SA 2921. Ms. STABENOW (for herself and Mrs. MCCASKILL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr.

REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

Subtitle C—Provisions Related to Improving Tax Incentives for Individuals and Employers Under Title I

PART I—GENERAL PROVISIONS

SEC. 9031. PREMIUM ASSISTANCE CREDIT.

(a) IN GENERAL.—Section 36B(b)(3)(A)(i) of the Internal Revenue Code of 1986, as added by section 1401, is amended by striking ''7'' each place it appears and inserting ''6''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in section 1401.

SEC. 9032. SMALL EMPLOYER HEALTH INSURANCE CREDIT.

(a) IN GENERAL.—Notwithstanding section 1421(f) of this Act—

(1) the amendments made by subsections (a), (b), (d), and (e) of section 1421 shall apply to taxable years beginning after December 31, 2009, and

(2) the amendments made by subsection (c) of section 1421 shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2009.

(b) CONFORMING AMENDMENTS.—

(1) Clause (i) of section 45R(d)(3)(B) of the Internal Revenue Code of 1986, as added by section 1421, is amended by inserting ''2010,'' before ''2011'' each place it appears in the text and in the heading.

(2) Subsection (g) of section 45R of such Code, as added by section 1421, is amended by inserting ''2010,'' before ''2011'' each place it appears in the text and in the heading.

(3) Section 280C(h) of such Code, as added by section 1421, is amended by inserting ''2010,'' before ''2011''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2009.

PART II—REVENUE PROVISIONS

SEC. 9035. SURTAX ON INVESTMENT INCOME.

(a) IN GENERAL.—

(1) SURTAX.—

(A) IMPOSITION OF TAX.—Subtitle A of the Internal Revenue Code of 1986 is amended by redesignating chapter 3 as chapter 4 and by inserting after chapter 2 the following new chapter:

''CHAPTER 3—TAX ON INVESTMENT INCOME

''Sec. 1411. Rate of tax.
''Sec. 1412. Investment income.

''SEC. 1411. RATE OF TAX.

''(a) IN GENERAL.—In addition to other taxes, there shall be imposed for each taxable year on the investment income of every taxpayer (other than a corporation, estate, or trust) a tax equal to 1.45 percent of such investment income for such taxable year.

''(b) PHASE-IN OF RATE.—The rate under subsection (a) (determined without regard to this subsection) shall be reduced (but not below zero) by the amount which bears the same ratio to such rate as—

''(1) the excess of—

''(A) $240,000 ($290,000 in the case of a joint return), over

''(B) the taxpayer's adjusted gross income for the taxable year, bears to

''(2) $40,000.

''SEC. 1412. INVESTMENT INCOME.

''(a) IN GENERAL.—For purposes of this chapter, the term 'investment income' means the sum of—

''(1) capital gain net income, and

''(2) net investment income.

''(b) NET INVESTMENT INCOME.—For purposes of this chapter, the term 'net investment income' means the net income (other than income which is included in self-employment income for purposes of chapter 2) from—

''(1) dividends,

''(2) interest (other than interest which is excludable from income under chapter 1), and

''(3) investment property income.

''(c) INVESTMENT PROPERTY.—For purposes of this chapter, the term 'investment property income' means income (determined after taking into account any deduction allowed under chapter 1 with respect to such income) derived from—

''(1) any property held for the production of rents or royalties,

''(2) any partnership or S corporation,

''(3) any estate or trust in which the taxpayer is a beneficiary, and

''(4) any real estate mortgage investment conduit in which the taxpayer is a residual holder.

''(d) TAXABLE YEARS ENDING AS THE RESULT OF A DEATH.—Rules similar to the rules of section 1402(f) shall apply with respect to investment income in a taxable year which ends as a result of the death of the taxpayer.''.

(2) ESTIMATED TAXES.—Section 6654 of the Internal Revenue Code of 1986 is amended —

(A) in subsection (a), by striking ''and the tax under chapter 2'' and inserting ''the tax under chapter 2, and the tax under chapter 3'', and

(B) in subsection (f)—

(i) by striking ''minus'' at the end of paragraph (2) and inserting ''plus'', and

(ii) by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

''(3) the taxed imposed by chapter 3, minus''.

(3) RETURNS.—

(A) IN GENERAL.—Subpart B of part II of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 6017A. INVESTMENT INCOME TAX RETURNS.

''Every taxpayer (other than a corporation, estate, or trust) having investment income for the taxable year shall make a return with respect to the investment income tax imposed by chapter 3.''.

(B) CONFORMING AMENDMENT.—The table of sections for subpart B of part II of subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Sec. 6017A. Investment income tax returns.''.

(4) CONFORMING AMENDMENTS.—

(A) The following sections of the Internal Revenue Code of 1986 are amended by striking ''chapter 3'' and inserting ''chapter 4'' each place it appears:

(i) Section 33.
(ii) Section 864(b).
(iii) Section 871(k)(1)(B)(ii).
(iv) Section 877A(d)(5).
(v) Section 896(a).
(vi) Section 3402(t)(2)(A).
(vii) Section 3405(e)(1)(B)(iii).
(viii) Paragraphs (2)(C)(iv), (5)(A), and (5)(B) of section 6049(b).
(ix) Section 6414.
(x) Paragraphs (1) and (2) of section 6501(b).
(xi) Subsections (b)(3) and (c) of section 6513.
(xii) Paragraphs (1) and (2) of section 6724(d).

(B) CLERICAL AMENDMENT.—The table of chapters for subtitle A of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating the item relating to chapter 3 as relating to chapter 4 and by inserting after the item relating to chapter 2 the following new item:

''CHAPTER 3—TAX ON INVESTMENT INCOME''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2012.

(b) TRANSFER OF AMOUNTS TO FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended by striking ''and'' at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting ''; and'', and by inserting after paragraph (2) the following new paragraph:

''(3) the taxes imposed by section 1411 of the Internal Revenue Code of 1986 with respect to investment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such investment income, which investment income shall be certified by the Commissioner of Social Security on the basis of records of investment income established and maintained by the Commissioner of Social Security.''.

SA 2922. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 567, after line 19, add the following:

SEC. 2903. FUNDING FOR CONTRACT MEDICAL CARE FOR INDIANS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

''SEC. 826. FUNDING FOR CONTRACT MEDICAL CARE.

''(a) APPROPRIATION.—For the purpose of the Secretary, acting through the Service, providing payment for contract medical care to Indians, there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed—

''(1) for fiscal year 2010, $625,000,000;

''(2) for fiscal year 2011, $2,500,000,000;

''(3) for each of fiscal years 2012 through 2014, the limit specified under this subsection for the preceding fiscal year, increased by the percentage increase (if any) in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year; and

''(4) for the first quarter of fiscal year 2015, one-fourth of the limit specified under this subsection for fiscal year 2014, increased by the percentage increase (if any) in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year.

''(b) NO EFFECT ON OTHER FUNDING FOR THIS ACT; AVAILABILITY.—Funds appropriated under subsection (a) shall—

''(1) be in addition to any other amounts made available under law (including under a

provision of this Act, the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or any other law) for payment for providing contract medical care to Indians; and

''(2) remain available until expended.

''(c) STUDY AND REPORT.—Not later than October 1, 2015, the Secretary shall study and submit a report to the Committee on Natural Resources of the House of Representatives and the Committee on Indian Affairs of the Senate on the extent to which the funds appropriated under this section have assisted in reducing health disparities among Indians.

''(d) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for payment of the amounts provided under subsection (a).

''(e) DEFINITION.—In this section, the term 'Indian health program' means—

''(1) any health program administered directly by the Service;

''(2) any tribal health program; and

''(3) any Indian tribe or tribal organization to which the Secretary of Health and Human Services provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').''.

SA 2923. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BEGICH, Mr. JOHNSON, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TESTER, and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, add the following:

DIVISION B—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND EXTENSION

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Health Care Improvement Reauthorization and Extension Act of 2009''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND AMENDMENTS

SEC. 101. REAUTHORIZATION.

(a) IN GENERAL.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended to read as follows:

''SEC. 825. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.''.

(b) REPEALS.—The following provisions of the Indian Health Care Improvement Act are repealed:

(1) Section 123 (25 U.S.C. 1616p).

(2) Paragraph (6) of section 209(m) (25 U.S.C. 1621h(m)).

(3) Subsection (g) of section 211 (25 U.S.C. 1621j).

(4) Subsection (e) of section 216 (25 U.S.C. 1621o).

(5) Section 224 (25 U.S.C. 1621w).

(6) Section 309 (25 U.S.C. 1638a).

(7) Section 407 (25 U.S.C. 1647).

(8) Subsection (c) of section 512 (25 U.S.C. 1660b).

(9) Section 514 (25 U.S.C. 1660d).

(10) Section 603 (25 U.S.C. 1663).

(11) Section 805 (25 U.S.C. 1675).

(c) CONFORMING AMENDMENTS.—

(1) Section 204(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1621c(c)(1)) is amended by striking ''through fiscal year 2000''.

(2) Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621*l*) is amended by striking ''(a) The Secretary'' and inserting ''The Secretary''.

(3) Section 310 of the Indian Health Care Improvement Act (25 U.S.C. 1638b) is amended by striking ''funds provided pursuant to the authorization contained in section 309'' each place it appears and inserting ''funds made available to carry out this title''.

SEC. 102. FINDINGS.

Section 2 of the Indian Health Care Improvement Act (25 U.S.C. 1601) is amended—

(1) by redesignating subsections (a), (b), (c), and (d) as paragraphs (1), (3), (4), and (5), respectively, and indenting the paragraphs appropriately; and

(2) by inserting after paragraph (1) (as so redesignated) the following:

''(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.''.

SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

Section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended to read as follows:

"SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

''(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

''(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

''(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

''(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.''.

SEC. 104. DEFINITIONS.

Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) is amended—

(1) by striking the matter preceding subsection (a) and inserting ''In this Act:'';

(2) in each of subsections (c), (j), (k), and (l), by redesignating the paragraphs contained in the subsections as subparagraphs and indenting the subparagraphs appropriately;

(3) by redesignating subsections (a) through (q) as paragraphs (17), (18), (13), (14), (26), (28), (27), (29), (1), (20), (11), (7), (19), (10), (21), (8), and (9), respectively, indenting the paragraphs appropriately, and moving the paragraphs so as to appear in numerical order;

(4) in each paragraph (as so redesignated), by inserting a heading the text of which is comprised of the term defined in the paragraph;

(5) by inserting ''The term'' after each paragraph heading;

(6) by inserting after paragraph (1) (as redesignated by paragraph (3)) the following:

''(2) BEHAVIORAL HEALTH.—

''(A) IN GENERAL.—The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

''(B) INCLUSIONS.—The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(3) CALIFORNIA INDIAN.—The term 'California Indian' means any Indian who is eligible for health services provided by the Service pursuant to section 809.

''(4) COMMUNITY COLLEGE.—The term 'community college' means—

''(A) a tribal college or university; or

''(B) a junior or community college.

''(5) CONTRACT HEALTH SERVICE.—The term 'contract health service' means any health service that is—

''(A) delivered based on a referral by, or at the expense of, an Indian health program; and

''(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

''(6) DEPARTMENT.—The term 'Department', unless otherwise designated, means the Department of Health and Human Services.'';

(7) by striking paragraph (7) (as redesignated by paragraph (3)) and inserting the following:

''(7) DISEASE PREVENTION.—

''(A) IN GENERAL.—The term 'disease prevention' means any activity for—

''(i) the reduction, limitation, and prevention of—

''(I) disease; and

''(II) complications of disease; and

''(ii) the reduction of consequences of disease.

''(B) INCLUSIONS.—The term 'disease prevention' includes an activity for—

''(i) controlling—

''(I) the development of diabetes;

''(II) high blood pressure;

''(III) infectious agents;

''(IV) injuries;

''(V) occupational hazards and disabilities;

''(VI) sexually transmittable diseases; or

''(VII) toxic agents; or

''(ii) providing—

''(I) fluoridation of water; or

''(II) immunizations.'';

(8) by striking paragraph (9) (as redesignated by paragraph (3)) and inserting the following:

''(9) FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(C) Prenatal or postnatal growth delay.'';

(9) by striking paragraphs (11) and (12) (as redesignated by paragraph (3)) and inserting the following:

''(11) HEALTH PROMOTION.—The term 'health promotion' means any activity for—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness regarding health matters and enabling individuals to cope with health problems by increasing knowledge and providing valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in accordance with physical and mental capacity;

''(D) making available safe water and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting culturally competent care; and

''(G) providing adequate and appropriate programs, including programs for—

''(i) abuse prevention (mental and physical);

''(ii) community health;

''(iii) community safety;

''(iv) consumer health education;

''(v) diet and nutrition;

''(vi) immunization and other methods of prevention of communicable diseases, including HIV/AIDS;

''(vii) environmental health;

''(viii) exercise and physical fitness;

''(ix) avoidance of fetal alcohol spectrum disorders;

''(x) first aid and CPR education;

''(xi) human growth and development;

''(xii) injury prevention and personal safety;

''(xiii) behavioral health;

''(xiv) monitoring of disease indicators between health care provider visits through appropriate means, including Internet-based health care management systems;

''(xv) personal health and wellness practices;

''(xvi) personal capacity building;

''(xvii) prenatal, pregnancy, and infant care;

''(xviii) psychological well-being;

''(xix) reproductive health and family planning;

''(xx) safe and adequate water;

''(xxi) healthy work environments;

''(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

''(xxiii) stress control;

''(xxiv) substance abuse;

''(xxv) sanitary facilities;

''(xxvi) sudden infant death syndrome prevention;

''(xxvii) tobacco use cessation and reduction;

''(xxviii) violence prevention; and

''(xxix) such other activities identified by the Service, a tribal health program, or an urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

''(12) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means—

''(A) any health program administered directly by the Service;

''(B) any tribal health program; and

''(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').'';

(10) by inserting after paragraph (14) (as redesignated by paragraph (3)) the following:

''(15) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(16) RESERVATION.—

''(A) IN GENERAL.—The term 'reservation' means a reservation, Pueblo, or colony of any Indian tribe.

''(B) INCLUSIONS.—The term 'reservation' includes—

''(i) former reservations in Oklahoma;

''(ii) Indian allotments; and

''(iii) Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).'';

(11) by striking paragraph (20) (as redesignated by paragraph (3)) and inserting the following:

''(20) SERVICE UNIT.—The term 'Service unit' means an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.'';

(12) by inserting after paragraph (21) (as redesignated by paragraph (3)) the following:

''(22) TELEHEALTH.—The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(23) TELEMEDICINE.—The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(24) TRIBAL COLLEGE OR UNIVERSITY.—The term 'tribal college or university' has the meaning given the term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(25) TRIBAL HEALTH PROGRAM.—The term 'tribal health program' means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''; and

(13) by striking paragraph (26) (as redesignated by paragraph (3)) and inserting the following:

''(26) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).''.

Subtitle A—Indian Health Manpower

SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.

Section 119 of the Indian Health Care Improvement Act (25 U.S.C. 1616*l*) is amended to read as follows:

''SEC. 119. COMMUNITY HEALTH AIDE PROGRAM.

''(a) GENERAL PURPOSES OF PROGRAM.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in the State of Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses those aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near those villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that those aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education regarding the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system that identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to ensure the provision of quality health care, health promotion, and disease prevention services; and

''(7) ensure that—

''(A) pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment; and

''(B) dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, subject to the condition that uncomplicated extractions shall not be considered oral surgery under this section.

''(c) PROGRAM REVIEW.—

''(1) NEUTRAL PANEL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

''(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

''(2) STUDY.—

''(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

''(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

''(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

''(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

''(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

''(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

''(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska tribal organizations with respect to the adequacy and accuracy of the study.

''(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

''(A) any determination of the neutral panel under paragraph (2)(C); and

''(B) any comments received from Alaska tribal organizations under paragraph (2)(D).

''(d) NATIONALIZATION OF PROGRAM.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

''(2) REQUIREMENT; EXCLUSION.—In establishing a national program under paragraph (1), the Secretary—

''(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and

''(B) shall exclude dental health aide therapist services from services covered under the program.''.

SEC. 112. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS.—The Secretary, acting through the Service, may fund demonstration programs for Indian health programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs under subsection (a) shall be—

''(1) to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by ensuring access to qualified health professionals;

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region; and

''(4) to provide training and support for alternative provider types, such as community health representatives, and community health aides.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board, which may be composed of representatives of tribal governments, Indian health programs, and Indian communities in the areas to be served by the demonstration programs.''.

SEC. 113. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 112) is amended by adding at the end the following:

''SEC. 124. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

''Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by a Federal agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees.''.

Subtitle B—Health Services

SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.

Section 201 of the Indian Health Care Improvement Act (25 U.S.C. 1621) is amended to read as follows:

''SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend

funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

''(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and improvement.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

''(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

''(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

''(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.''.

SEC. 122. CATASTROPHIC HEALTH EMERGENCY FUND.

Section 202 of the Indian Health Care Improvement Act (25 U.S.C. 1621a) is amended to read as follows:

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

''(A) Service Units; or

''(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

''(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other law.

''(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.''.

SEC. 123. DIABETES PREVENTION, TREATMENT, AND CONTROL.

Section 204 of the Indian Health Care Improvement Act (25 U.S.C. 1621c) is amended to read as follows:

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian tribes and tribal organizations, shall determine—

''(1) by Indian tribe and by Service unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that Service unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a tribal health program and may be conducted through appropriate Internet-based health care management programs.

''(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, any such other diabetes programs operated by the Service or tribal health programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian tribes. tribal health programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 and for projects which are added and funded thereafter.

''(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian tribes, and tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

''(A) in each area office, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

''(B) establish in each area office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(C) ensure that data collected in each area office regarding diabetes and related complications among Indians are disseminated to all other area offices, subject to applicable patient privacy laws.

''(2) DIABETES CONTROL OFFICERS.—

''(A) IN GENERAL.—The Secretary may establish and maintain in each area office a position of diabetes control officer to coordinate and manage any activity of that area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

''(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.''.

SEC. 124. OTHER AUTHORITY FOR PROVISION OF SERVICES; SHARED SERVICES FOR LONG-TERM CARE.

(a) OTHER AUTHORITY FOR PROVISION OF SERVICES.—

(1) IN GENERAL.—Section 205 of the Indian Health Care Improvement Act (25 U.S.C. 1621d) is amended to read as follows:

"SEC. 205. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) DEFINITIONS.—In this section:

''(1) ASSISTED LIVING SERVICE.—The term 'assisted living service' means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

''(A) shall not be required to obtain a license; but

''(B) shall meet all applicable standards for licensure.

''(2) HOME- AND COMMUNITY-BASED SERVICE.—The term 'home- and community-based service' means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

''(3) HOSPICE CARE.—The term 'hospice care' means—

''(A) the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

''(B) such other services as an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of that care.

''(4) LONG-TERM CARE SERVICES.—The term 'long-term care services' has the meaning given the term 'qualified long-term care services' in section 7702B(c) of the Internal Revenue Code of 1986.

''(b) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act for the following services:

''(1) Hospice care.

''(2) Assisted living services.

''(3) Long-term care services.

''(4) Home- and community-based services.

''(c) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care services under this section:

''(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

''(2) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

''(3) Such other individuals as an applicable tribal health program determines to be appropriate.

''(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may also provide funding under this Act to meet the objectives set forth in section 3 for convenient care services programs pursuant to section 307(c)(2)(A).''.

(2) REPEAL.—Section 821 of the Indian Health Care Improvement Act (25 U.S.C. 1680k) is repealed.

(b) SHARED SERVICES FOR LONG-TERM CARE.—Section 822 of the Indian Health Care Improvement Act (25 U.S.C. 1680*l*) is amended to read as follows:

"SEC. 822. SHARED SERVICES FOR LONG-TERM CARE.

''(a) LONG-TERM CARE.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians.

''(2) INCLUSIONS.—Each agreement under paragraph (1) shall provide for the sharing of staff or other services between the Service or a tribal health program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by the Indian tribe or tribal organization.

''(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian tribe or tribal organization, delegate to the Indian tribe or tribal organization such powers of supervision and control over Service employees as the Secretary determines to be necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal health program be allocated proportionately between the Service and the Indian tribe or tribal organization; and

''(3) may authorize the Indian tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act (42 U.S.C. 1396r).

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused, or allow the use of swing beds, for long-term or similar care.''.

SEC. 125. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

Section 206 of the Indian Health Care Improvement Act (25 U.S.C. 1621e) is amended to read as follows:

"SEC. 206. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible

to receive damages, reimbursement, or indemnification for such charges or expenses if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICABILITY OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian tribe, or tribal organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a separate civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(3) RECOVERY FROM TORTFEASORS.—

''(A) IN GENERAL.—In any case in which an Indian tribe or tribal organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian tribe or tribal organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

''(B) TREATMENT.—The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEY'S FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorney's fees and costs of litigation.

''(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian tribes and tribal organizations with respect to populations served by such Indian tribes and tribal organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian tribes, tribal organizations, and urban Indian organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian tribe, or tribal organization under the provisions of any applicable, Federal, State, or tribal law, including medical lien laws.''.

SEC. 126. CREDITING OF REIMBURSEMENTS.

Section 207 of the Indian Health Care Improvement Act (25 U.S.C. 1621f) is amended to read as follows:

''SEC. 207. CREDITING OF REIMBURSEMENTS.

''(a) USE OF AMOUNTS.—

''(1) RETENTION BY PROGRAM.—Except as provided in sections 202(a)(2) and 813, all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provision of health services by the Service, by an Indian tribe or tribal organization, or by an urban Indian organization, shall be credited to the Service, such Indian tribe or tribal organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

''(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

''(A) Titles XVIII, XIX, and XXI of the Social Security Act.

''(B) This Act, including section 813.

''(C) Public Law 87–693.

''(D) Any other provision of law.

''(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).''.

SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

Section 209 of the Indian Health Care Improvement Act (25 U.S.C. 1621h) is amended by striking subsection (d) and inserting the following:

''(d) BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—

''(1) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian tribes and tribal organizations, shall conduct a study and compile a list of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

''(2) POSITIONS.—The positions referred to in paragraph (1) are—

''(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(i) elementary and secondary education;

''(ii) social services and family and child welfare;

''(iii) law enforcement and judicial services; and

''(iv) alcohol and substance abuse;

''(B) staff positions within the Service; and

''(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes and tribal organizations (without regard to the funding source).

''(3) TRAINING CRITERIA.—

''(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraphs (2)(A) and (2)(B) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian tribe or tribal organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

''(B) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(4) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian tribe, tribal organization, or urban Indian organization, or assist the Indian tribe, tribal organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this paragraph, the Service shall, upon request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(5) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension

Act of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of that Act, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this paragraph shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').''.

SEC. 128. CANCER SCREENINGS.

Section 212 of the Indian Health Care Improvement Act (25 U.S.C. 1621k) is amended by inserting ''and other cancer screenings'' before the period at the end.

SEC. 129. PATIENT TRAVEL COSTS.

Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621l) is amended to read as follows:

''SEC. 213. PATIENT TRAVEL COSTS.

''(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

''(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

''(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

''(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

''(b) PROVISION OF FUNDS.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

''(1) emergency air transportation and nonemergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.''.

SEC. 130. EPIDEMIOLOGY CENTERS.

Section 214 of the Indian Health Care Improvement Act (25 U.S.C. 1621m) is amended to read as follows:

''SEC. 214. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT OF CENTERS.—

''(1) IN GENERAL.—The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

''(2) NEW CENTERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), any new center established after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 may be operated under a grant authorized by subsection (d).

''(B) REQUIREMENT.—Funding provided in a grant described in subparagraph (A) shall not be divisible.

''(3) FUNDS NOT DIVISIBLE.—An epidemiology center established under this subsection shall be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for the center shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and urban Indians;

''(6) provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian tribes, tribal organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

''(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium is—

''(A) incorporated for the primary purpose of improving Indian health; and

''(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

''(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

''(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

''(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

''(5) USE OF FUNDS.—A grant provided under paragraph (1) may be used—

''(A) to carry out the functions described in subsection (b);

''(B) to provide information to, and consult with, tribal leaders, urban Indian community leaders, and related health staff regarding health care and health service management issues; and

''(C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.

''(e) ACCESS TO INFORMATION.—

''(1) IN GENERAL.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).

''(2) ACCESS TO INFORMATION.—The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

''(3) REQUIREMENT.—The activities of an epidemiology center described in paragraph (1) shall be for the purposes of research and for preventing and controlling disease, injury, or disability (as those activities are described in section 164.512 of title 45, Code of Federal Regulations (or a successor regulation)), for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).''.

SEC. 131. INDIAN YOUTH GRANT PROGRAM.

Section 216(b)(2) of the Indian Health Care Improvement Act (25 U.S.C. 1621o(b)(2)) is amended by striking ''section 209(m)'' and inserting ''section 708(c)''.

SEC. 132. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

Section 217 of the Indian Health Care Improvement Act (25 U.S.C. 1621p) is amended to read as follows:

''SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian health programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

''(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

''(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

''(7) to the maximum extent feasible, employs qualified Indians in the program.

''(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian health program;

''(2) in a program assisted under title V; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for fiscal year 2010 and each fiscal year thereafter.''.

SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

Section 218 of the Indian Health Care Improvement Act (25 U.S.C. 1621q) is amended to read as follows:

''SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian tribes and tribal organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. pylori.

''(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

''(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

''(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian tribes and tribal organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.''.

SEC. 134. METHODS TO INCREASE CLINICIAN RECRUITMENT AND RETENTION ISSUES.

(a) LICENSING.—Section 221 of the Indian Health Care Improvement Act (25 U.S.C. 1621t) is amended to read as follows:

''SEC. 221. LICENSING.

''Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

(b) TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.—Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 113) is amended by adding at the end the following:

''SEC. 125. TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.

''A scholarship provided to an individual pursuant to this title shall be considered to be a qualified scholarship for purposes of section 117 of the Internal Revenue Code of 1986.''.

(c) CONTINUING EDUCATION ALLOWANCES.—Section 106 of the Indian Health Care Improvement Act (25 U.S.C. 1615) is amended to read as follows:

''SEC. 106. CONTINUING EDUCATION ALLOWANCES.

''In order to encourage scholarship and stipend recipients under sections 104, 105, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian health program and to provide services in the rural and remote areas in which a significant portion of Indians reside, the Secretary, acting through the Service, may—

''(1) provide programs or allowances to transition into an Indian health program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, and 115; and

''(2) provide programs or allowances to health professionals employed in an Indian health program to enable those professionals, for a period of time each year prescribed by regulation of the Secretary, to take leave of the duty stations of the professionals for professional consultation, management, leadership, and refresher training courses.''.

SEC. 135. LIABILITY FOR PAYMENT.

Section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621u) is amended to read as follows:

''SEC. 222. LIABILITY FOR PAYMENT.

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.''.

SEC. 136. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

Section 223 of the Indian Health Care Improvement Act (25 U.S.C. 1621v) is amended—

(1) by striking the section designation and heading and all that follows through ''oversee efforts of the Service to'' and inserting the following:

''SEC. 223. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

''(a) OFFICE OF INDIAN MEN'S HEALTH.—

''(1) ESTABLISHMENT.—The Secretary may establish within the Service an office, to be known as the 'Office of Indian Men's Health'.

''(2) DIRECTOR.—

''(A) IN GENERAL.—The Office of Indian Men's Health shall be headed by a director, to be appointed by the Secretary.

''(B) DUTIES.—The director shall coordinate and promote the health status of Indian men in the United States.

''(3) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall submit to Congress a report describing—

''(A) any activity carried out by the director as of the date on which the report is prepared; and

''(B) any finding of the director with respect to the health of Indian men.

''(b) OFFICE OF INDIAN WOMEN'S HEALTH.—The Secretary, acting through the Service, shall establish an office, to be known as the 'Office of Indian Women's Health', to''; and

(2) in subsection (b) (as so redesignated) by inserting ''(including urban Indian women)'' before ''of all ages''.

SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621 et seq.) is amended by adding at the end the following:

''SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

''(a) SUBMISSION OF REPORT.—As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General of the United States shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available to each Indian tribe, a report describing the results of the study of the Comptroller General regarding the funding of the contract health service program (including historic funding levels and a recommendation of the funding level needed for the program) and the administration of the contract health service program (including the distribution of funds pursuant to the program), as requested by Congress in March 2009, or pursuant to section 830.

''(b) CONSULTATION WITH TRIBES.—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program—

''(1) to determine whether the current distribution formula would require modification if the contract health service program were funded at the level recommended by the Comptroller General;

''(2) to identify any inequities in the current distribution formula under the current funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

''(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program; and

''(4) to identify any other issues and recommendations to improve the administration of the contract health services program and correct any unfair results or funding disparities identified under paragraph (2).

''(c) SUBSEQUENT ACTION BY SECRETARY.—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b)(2) exists, the Secretary may initiate procedures under subchapter III of chapter 5 of

title 5, United States Code, to negotiate or promulgate regulations to establish a disbursement formula for the contract health service program funding.''.

Subtitle C—Health Facilities

SEC. 141. HEALTH CARE FACILITY PRIORITY SYSTEM.

Section 301 of the Indian Health Care Improvement Act (25 U.S.C. 1631) is amended—

(1) by redesignating subsection (d) as subsection (h); and

(2) by striking subsection (c) and inserting the following:

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

''(i) shall be developed in consultation with Indian tribes and tribal organizations;

''(ii) shall give Indian tribes' needs the highest priority;

''(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

''(II) shall include the methodology required in paragraph (2)(B)(v); and

''(III) may include such health care facilities, and such renovation or expansion needs of any health care facility, as the Service may identify; and

''(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

''(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

''(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

''(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

''(i) was identified in the fiscal year 2008 Service budget justification as—

''(I) 1 of the 10 top-priority inpatient projects;

''(II) 1 of the 10 top-priority outpatient projects;

''(III) 1 of the 10 top-priority staff quarters developments; or

''(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

''(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

''(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

''(I) on the initiative of the Secretary; or

''(II) pursuant to a request of an Indian tribe or tribal organization.

''(2) REPORT; CONTENTS.—

''(A) INITIAL COMPREHENSIVE REPORT.—

''(i) DEFINITIONS.—In this subparagraph:

''(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term 'Facilities Appropriation Advisory Board' means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director—

''(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

''(bb) to address other facilities issues.

''(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term 'Facilities Needs Assessment Workgroup' means the workgroup established at the discretion of the Director—

''(aa) to review the health care facilities construction priority system; and

''(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

''(ii) INITIAL REPORT.—

''(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

''(II) INCLUSIONS.—The initial report shall include—

''(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

''(bb) such other information as the Secretary determines to be appropriate.

''(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

''(I) update the report under clause (ii) not less frequently that once every 5 years; and

''(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

''(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(i) A description of the health care facility priority system of the Service established under paragraph (1).

''(ii) Health care facilities lists, which may include—

''(I) the 10 top-priority inpatient health care facilities;

''(II) the 10 top-priority outpatient health care facilities;

''(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment); and

''(IV) the 10 top-priority staff quarters developments associated with health care facilities.

''(iii) The justification for such order of priority.

''(iv) The projected cost of such projects.

''(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

''(A) consult with and obtain information on all health care facilities needs from Indian tribes and tribal organizations; and

''(B) review the total unmet needs of all Indian tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

''(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

''(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

''(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

''(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

''(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

''(A) the Committees on Indian Affairs and Appropriations of the Senate;

''(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

''(C) the Secretary.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) or sections 504 and 505 of that Act (25 U.S.C. 458aaa–3, 458aaa–4).

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include—

''(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

''(2) approaches provided for in other provisions of this title; and

''(3) other approaches, as the Secretary determines to be appropriate.''.

SEC. 142. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

Section 307 of the Indian Health Care Improvement Act (25 U.S.C. 1637) is amended to read as follows:

''SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

''(a) PURPOSE AND GENERAL AUTHORITY.—

''(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary, acting through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

''(A) to test alternative means of delivering health care and services to Indians through facilities; or

''(B) to use alternative or innovative methods or models of delivering health care services to Indians (including primary care services, contract health services, or any other program or service authorized by this Act) through convenient care services (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share or coordinate the use of facilities, funding, or other resources, or otherwise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

''(2) AUTHORITY.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

''(A) test alternative means of delivering health care and services to Indians through facilities; or

''(B) otherwise carry out the purposes of this section.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section—

''(1) may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services; and

''(2) is authorized—

''(A) to waive any leasing prohibition;

''(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health benefits coverage, as authorized by section 402(a));

''(C) to permit the use of other available funds, including other Federal funds, funds from third-party collections in accordance with sections 206, 207, and 401, and non-Federal funds contributed by State or local governmental agencies or facilities or private health care providers pursuant to cooperative or other agreements with the Service, 1 or more Indian tribes, or tribal organizations;

''(D) to permit the use of funds or property donated or otherwise provided from any source for project purposes;

''(E) to provide for the reversion of donated real or personal property to the donor; and

''(F) to permit the use of Service funds to match other funds, including Federal funds.

''(c) HEALTH CARE DEMONSTRATION PROJECTS.—

''(1) DEFINITION OF CONVENIENT CARE SERVICE.—In this subsection, the term 'convenient care service' means any primary health care service, such as urgent care services, nonemergent care services, prevention services and screenings, and any service authorized by section 203 or 205(d), that is offered—

''(A) at an alternative setting; or

''(B) during hours other than regular working hours.

''(2) GENERAL PROJECTS.—

''(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

''(i) There is a need for a new facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

''(ii) A significant number of Indians, including Indians with low health status, will be served by the project.

''(iii) The project has the potential to deliver services in an efficient and effective manner.

''(iv) The project is economically viable.

''(v) For projects carried out by an Indian tribe or tribal organization, the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(vi) The project is integrated with providers of related health or social services (including State and local health care agencies or other health care providers) and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

''(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service units:

''(i) Cass Lake, Minnesota.

''(ii) Mescalero, New Mexico.

''(iii) Owyhee and Elko, Nevada.

''(iv) Schurz, Nevada.

''(v) Ft. Yuma, California.

''(3) INNOVATIVE HEALTH SERVICES DELIVERY DEMONSTRATION PROJECT.—

''(A) APPLICATION OR REQUEST.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services within the Service area (or a portion of, or facility within, the Service area) as described in the application or request, including medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

''(B) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized under this paragraph to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (C).

''(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

''(i) The criteria set forth in paragraph (2)(A).

''(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

''(iii) The project—

''(I) expands the availability of services; or

''(II) reduces—

''(aa) the burden on Contract Health Services; or

''(bb) the need for emergency room visits.

''(d) TECHNICAL ASSISTANCE.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization, the Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section, including information regarding the Service unit budget and available funding for carrying out the proposed demonstration project.

''(e) SERVICE TO INELIGIBLE PERSONS.—Subject to section 813, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

''(f) EQUITABLE TREATMENT.—For purposes of subsection (c), the Secretary, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities that are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.''.

SEC. 143. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

Title III of the Indian Health Care Improvement Act (as amended by section 101(b)) is amended by inserting after section 308 (25 U.S.C. 1638) the following:

''SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a tribal health program that operates a hospital or other health facility and the federally owned quarters associated with such a facility pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may establish the rental rates charged to the occupants of those quarters, on providing notice to the Secretary.

''(2) OBJECTIVES.—In establishing rental rates under this subsection, a tribal health program shall attempt—

''(A) to base the rental rates on the reasonable value of the quarters to the occupants of the quarters; and

''(B) to generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and at the discretion of the tribal health program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—A federally owned quarters the rental rates for which are established by a tribal health program under this subsection shall remain eligible to receive improvement and repair funds to the same extent that all federally owned quarters used to house personnel in programs of the Service are eligible to receive those funds.

''(4) NOTICE OF RATE CHANGE.—A tribal health program that establishes a rental rate under this subsection shall provide occupants of the federally owned quarters a notice of any change in the rental rate by not later than the date that is 60 days notice before the effective date of the change.

''(5) RATES IN ALASKA.—A rental rate established by a tribal health program under this section for a federally owned quarters in the State of Alaska may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a tribal health program may collect rent directly from Federal employees who occupy federally owned quarters if the tribal health program submits to the Secretary and the employees a notice of the election of the tribal health program to collect rents directly from the employees.

''(2) ACTION BY EMPLOYEES.—On receipt of a notice described in paragraph (1)—

''(A) the affected Federal employees shall pay rent for occupancy of a federally owned quarters directly to the applicable tribal health program; and

''(B) the Secretary shall not have the authority to collect rent from the employees through payroll deduction or otherwise.

''(3) USE OF PAYMENTS.—The rent payments under this subsection—

''(A) shall be retained by the applicable tribal health program in a separate account, which shall be used by the tribal health program for the maintenance (including capital repairs and replacement) and operation of the quarters, as the tribal health program determines to be appropriate; and

''(B) shall not be made payable to, or otherwise be deposited with, the United States.

''(4) RETROCESSION OF AUTHORITY.—If a tribal health program that elected to collect rent directly under paragraph (1) requests retrocession of the authority of the tribal health program to collect that rent, the retrocession shall take effect on the earlier of—

''(A) the first day of the month that begins not less than 180 days after the tribal health program submits the request; and

''(B) such other date as may be mutually agreed on by the Secretary and the tribal health program.''.

SEC. 144. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following:

''SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

''(a) AUTHORIZATION.—

''(1) AUTHORITY TO TRANSFER FUNDS.—The head of any Federal agency to which funds, equipment, or other supplies are made available for the planning, design, construction, or operation of a health care or sanitation facility may transfer the funds, equipment, or supplies to the Secretary for the planning, design, construction, or operation of a health care or sanitation facility to achieve—

''(A) the purposes of this Act; and

''(B) the purposes for which the funds, equipment, or supplies were made available to the Federal agency.

''(2) AUTHORITY TO ACCEPT FUNDS.—The Secretary may—

''(A) accept from any source, including Federal and State agencies, funds, equipment, or supplies that are available for the construction or operation of health care or sanitation facilities; and

''(B) use those funds, equipment, and supplies to plan, design, construct, and operate health care or sanitation facilities for Indians, including pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(3) EFFECT OF RECEIPT.—Receipt of funds by the Secretary under this subsection shall not affect any priority established under section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary may enter into interagency agreements with Federal or State agencies and other entities, and accept funds, equipment, or other supplies from those entities, to provide for the planning, design, construction, and operation of health care or sanitation facilities to be administered by Indian health programs to achieve—

''(1) the purposes of this Act; and

''(2) the purposes for which the funds were appropriated or otherwise provided.

''(c) ESTABLISHMENT OF STANDARDS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act.

''(2) OTHER REGULATIONS.—Notwithstanding any other provision of law, any other applicable regulations of the Department shall apply in carrying out projects using funds transferred under this section.

''(d) DEFINITION OF SANITATION FACILITY.—In this section, the term 'sanitation facility' means a safe and adequate water supply system, sanitary sewage disposal system, or sanitary solid waste system (including all related equipment and support infrastructure).''.

SEC. 145. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 144) is amended by adding at the end the following:

''SEC. 312. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

''(a) DEFINITION OF MODULAR COMPONENT HEALTH CARE FACILITY.—In this section, the term 'modular component health care facility' means a health care facility that is constructed—

''(1) off-site using prefabricated component units for subsequent transport to the destination location; and

''(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

''(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for purchase, installation and maintenance of modular component health care facilities in Indian communities for provision of health care services.

''(c) SELECTION OF LOCATIONS.—

''(1) PETITIONS.—

''(A) SOLICITATION.—The Secretary shall solicit from Indian tribes petitions for location of the modular component health care facilities in the Service areas of the petitioning Indian tribes.

''(B) PETITION.—To be eligible to receive a grant under this section, an Indian tribe or tribal organization must submit to the Secretary a petition to construct a modular component health care facility in the Indian community of the Indian tribe, at such time, in such manner, and containing such information as the Secretary may require.

''(2) SELECTION.—In selecting the location of each modular component health care facility to be provided under the demonstration program, the Secretary shall give priority to projects already on the Indian Health Service facilities construction priority list and petitions which demonstrate that erection of a modular component health facility—

''(A) is more economical than construction of a traditionally constructed health care facility;

''(B) can be constructed and erected on the selected location in less time than traditional construction; and

''(C) can adequately house the health care services needed by the Indian population to be served.

''(3) EFFECT OF SELECTION.—A modular component health care facility project selected for participation in the demonstration program shall not be eligible for entry on the facilities construction priorities list entitled 'IHS Health Care Facilities FY 2011 Planned Construction Budget' and dated May 7, 2009 (or any successor list).

''(d) ELIGIBILITY.—

''(1) IN GENERAL.—An Indian tribe may submit a petition under subsection (c)(1)(B) regardless of whether the Indian tribe is a party to any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(2) ADMINISTRATION.—At the election of an Indian tribe or tribal organization selected for participation in the demonstration program, the funds provided for the project shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

''(e) REPORTS.—Not later than 1 year after the date on which funds are made available for the demonstration program and annually thereafter, the Secretary shall submit to Congress a report describing—

''(1) each activity carried out under the demonstration program, including an evaluation of the success of the activity; and

''(2) the potential benefits of increased use of modular component health care facilities in other Indian communities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.''.

SEC. 146. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 145) is amended by adding at the end the following:

''SEC. 313. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE TRIBAL CONSORTIUM.—The term 'eligible tribal consortium' means a consortium composed of 2 or more Service units between which a mobile health station can be transported by road in up to 8 hours. A Service unit operated by the Service or by an Indian tribe or tribal organization shall be equally eligible for participation in such consortium.

''(2) MOBILE HEALTH STATION.—The term 'mobile health station' means a health care unit that—

''(A) is constructed, maintained, and capable of being transported within a semi-trailer truck or similar vehicle;

''(B) is equipped for the provision of 1 or more specialty health care services; and

''(C) can be equipped to be docked to a stationary health care facility when appropriate.

''(3) SPECIALTY HEALTH CARE SERVICE.—

''(A) IN GENERAL.—The term 'specialty health care service' means a health care service which requires the services of a health care professional with specialized knowledge or experience.

''(B) INCLUSIONS.—The term 'specialty health care service' includes any service relating to—

''(i) dialysis;

''(ii) surgery;

''(iii) mammography;

''(iv) dentistry; or

''(v) any other specialty health care service.

''(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall provide at least 3 mobile health station projects.

''(c) PETITION.—To be eligible to receive a mobile health station under the demonstration program, an eligible tribal consortium shall submit to the Secretary, a petition at such time, in such manner, and containing—

''(1) a description of the Indian population to be served;

''(2) a description of the specialty service or services for which the mobile health station is requested and the extent to which such service or services are currently available to the Indian population to be served; and

''(3) such other information as the Secretary may require.

''(d) USE OF FUNDS.—The Secretary shall use amounts made available to carry out the demonstration program under this section—

''(1)(A) to establish, purchase, lease, or maintain mobile health stations for the eligible tribal consortia selected for projects; and

''(B) to provide, through the mobile health station, such specialty health care services as the affected eligible tribal consortium determines to be necessary for the Indian population served;

''(2) to employ an existing mobile health station (regardless of whether the mobile health station is owned or rented and operated by the Service) to provide specialty health care services to an eligible tribal consortium; and

''(3) to establish, purchase, or maintain docking equipment for a mobile health station, including the establishment or maintenance of such equipment at a modular component health care facility (as defined in section 312(a)), if applicable.

''(e) REPORTS.—Not later than 1 year after the date on which the demonstration program is established under subsection (b) and annually thereafter, the Secretary, acting through the Service, shall submit to Congress a report describing—

''(1) each activity carried out under the demonstration program including an evaluation of the success of the activity; and

''(2) the potential benefits of increased use of mobile health stations to provide specialty health care services for Indian communities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 per year to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be needed to carry out the program in subsequent fiscal years.''.

Subtitle D—Access to Health Services

SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

Section 401 of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended to read as follows:

''SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

''(a) DISREGARD OF MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian health program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XI of the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—

''(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service unit makes collections, are entitled by reason of a provision of either such title.

''(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 201(c)) of such Indian tribes, including the provision of services pursuant to section 205.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a tribal health program upon the election of such program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such program during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any tribal health program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

''(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

''(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by tribal health programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A tribal health program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a tribal health program or in the direct billing program established under this subsection if the Secretary determines that the program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a tribal health program with notice of a determination that the program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the program's participation in the direct billing program established under this subsection.

''(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.''.

SEC. 152. PURCHASING HEALTH CARE COVERAGE.

Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended to read as follows:

''SEC. 402. PURCHASING HEALTH CARE COVERAGE.

''(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a contract health service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner, including through—

''(1) a tribally owned and operated health care plan;

''(2) a State or locally authorized or licensed health care plan;

''(3) a health insurance provider or managed care organization;

''(4) a self-insured plan; or

''(5) a high deductible or health savings account plan.

''(b) FINANCIAL NEED.—The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a schedule of income levels developed or implemented by such 1 ore more Indian tribes).

''(c) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).''.

SEC. 153. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

Section 404 of the Indian Health Care Improvement Act (25 U.S.C. 1644) is amended to read as follows:

''SEC. 404. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian tribes and tribal organizations to assist such tribes and tribal organizations in establishing and administering programs on or near reservations and trust lands, including programs to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

''(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

''(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian tribe or tribes or tribal organizations being served based on a schedule of income levels developed or implemented by such tribe, tribes, or tribal organizations).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include requirements that the Indian tribe or tribal organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

''(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian tribes and tribal organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to effect the purposes of this section.

''(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall develop and disseminate best practices that will serve to facilitate cooperation with, and agreements between, States and the Service, Indian tribes, tribal organizations, or urban Indian organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

''(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements of the Secretary, acting through the Service, for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

''(f) DEFINITION OF PREMIUMS AND COST SHARING.—In this section:

''(1) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(2) COST SHARING.—The term 'cost sharing' includes any deduction, deductible, copayment, coinsurance, or similar charge.''.

SEC. 154. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended to read as follows:

''SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian tribes, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.''.

SEC. 155. ELIGIBLE INDIAN VETERAN SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

''(a) FINDINGS; PURPOSE.—

''(1) FINDINGS.—Congress finds that—

''(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

''(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

''(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIAN VETERAN.—The term 'eligible Indian veteran' means an Indian or Alaska Native veteran who receives any medical service that is—

''(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

''(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

''(2) LOCAL MEMORANDUM OF UNDERSTANDING.—The term 'local memorandum of understanding' means a memorandum of understanding between the Secretary (or a designee, including the director of any area office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

''(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall

provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

''(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

''(d) TRIBAL APPROVAL OF MEMORANDA.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

''(e) FUNDING.—

''(1) TREATMENT.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not be considered to be Contract Health Service expenses.

''(2) USE OF FUNDS.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.''.

SEC. 156. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 155) is amended by adding at the end the following:

''SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

''(a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

''(2) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

''(b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—

''(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

''(2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

''(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

''(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian tribe, tribal organization, or urban Indian organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).''.

SEC. 157. ACCESS TO FEDERAL INSURANCE.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 156) is amended by adding at the end the following:

''SEC. 409. ACCESS TO FEDERAL INSURANCE.

''Notwithstanding the provisions of title 5, United States Code, Executive order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights, and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.''.

SEC. 158. GENERAL EXCEPTIONS.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 157) is amended by adding at the end the following:

''SEC. 410. GENERAL EXCEPTIONS.

''The requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91).''.

SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 158) is amended by adding at the end the following:

''SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

''(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

''(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

''(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

''(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

''(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

''(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.''.

Subtitle E—Health Services for Urban Indians

SEC. 161. FACILITIES RENOVATION.

Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659) is amended by inserting ''or construction or expansion of facilities'' after ''renovations to facilities''.

SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

Section 512 of the Indian Health Care Improvement Act (25 U.S.C. 1660b) is amended to read as follows:

''SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service units and operating units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

SEC. 163. REQUIREMENT TO CONFER WITH URBAN INDIAN ORGANIZATIONS.

(a) CONFERRING WITH URBAN INDIAN ORGANIZATIONS.—Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

"SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

''(a) DEFINITION OF CONFER.—In this section, the term 'confer' means to engage in an open and free exchange of information and opinions that—

''(1) leads to mutual understanding and comprehension; and

''(2) emphasizes trust, respect, and shared responsibility.

''(b) REQUIREMENT.—The Secretary shall ensure that the Service confers, to the maximum extent practicable, with urban Indian organizations in carrying out this Act.''.

(b) CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.—Section 502 of the Indian Health Care Improvement Act (25 U.S.C. 1652) is amended to read as follows:

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist the urban Indian organizations in the establishment and administration, within urban centers, of programs that meet the requirements of this title.

''(b) CONDITIONS.—Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.''.

SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 163(a)) is amended by adding at the end the following:

"SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

''Notwithstanding any other provision of this Act, the Secretary, acting through the Service, is authorized to establish programs, including programs for awarding grants, for urban Indian organizations that are identical to any programs established pursuant to sections 218, 702, and 708(g).''.

SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 164) is amended by adding at the end the following:

"SEC. 516. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representative Program under section 107 in the provision of health care, health promotion, and disease prevention services to urban Indians.''.

SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY; HEALTH INFORMATION TECHNOLOGY.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 165) is amended by adding at the end the following:

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out the contract or grant, to use, in accordance with such terms and conditions for use and maintenance as are agreed on by the Secretary and the urban Indian organizations—

''(1) any existing facility under the jurisdiction of the Secretary;

''(2) all equipment contained in or pertaining to such an existing facility; and

''(3) any other personal property of the Federal Government under the jurisdiction of the Secretary.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for the purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus personal or real property of the Federal Government for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for purposes of the contract or grant.

''(d) PRIORITY.—If the Secretary receives from an urban Indian organization or an Indian tribe or tribal organization a request for a specific item of personal or real property described in subsection (b) or (c), the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization, if the Secretary receives the request from the Indian tribe or tribal organization before the earlier of—

''(1) the date on which the Secretary transfers title to the property to the urban Indian organization; and

''(2) the date on which the Secretary transfers the property physically to the urban Indian organization.

''(e) EXECUTIVE AGENCY STATUS.—For purposes of section 501(a) of title 40, United States Code, an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be considered to be an Executive agency in carrying out the contract or grant.

"SEC. 518. HEALTH INFORMATION TECHNOLOGY.

''The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)), telemedicine services development, and related infrastructure.''.

Subtitle F—Organizational Improvements

SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended to read as follows:

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) DIRECTOR.—The Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall serve as Director.

''(4) ADVOCACY AND CONSULTATION.—The position of Director is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Director shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, carried out by or under the direction of the individual serving as Director of the Service on that day;

''(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians, including by ensuring that all agency directors, managers, and chief executive officers have appropriate and adequate training, experience, skill levels, knowledge, abilities, and education (including continuing training requirements) to competently fulfill the duties of the positions and the mission of the Service;

''(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(4) administer all scholarship and loan functions carried out under title I;

''(5) directly advise the Secretary concerning the development of all policy- and budget-related matters affecting Indian health;

''(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

''(9) coordinate the activities of the Department concerning matters of Indian health; and

''(10) perform such other functions as the Secretary may designate.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Director, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).''.

SEC. 172. OFFICE OF DIRECT SERVICE TRIBES.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.

''(a) ESTABLISHMENT.—There is established within the Service an office, to be known as the 'Office of Direct Service Tribes'.

''(b) TREATMENT.—The Office of Direct Service Tribes shall be located in the Office of the Director.

''(c) DUTIES.—The Office of Direct Service Tribes shall be responsible for—

''(1) providing Service-wide leadership, guidance and support for direct service tribes to include strategic planning and program evaluation;

''(2) ensuring maximum flexibility to tribal health and related support systems for Indian beneficiaries;

''(3) serving as the focal point for consultation and participation between direct service tribes and organizations and the Service in the development of Service policy;

''(4) holding no less than biannual consultations with direct service tribes in appropriate locations to gather information and aid in the development of health policy; and

''(5) directing a national program and providing leadership and advocacy in the development of health policy, program management, budget formulation, resource allocation, and delegation support for direct service tribes.''.

SEC. 173. NEVADA AREA OFFICE.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 172) is amended by adding at the end the following:

''SEC. 604. NEVADA AREA OFFICE.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, in a manner consistent with the tribal consultation policy of the Service, the Secretary shall submit to Congress a plan describing the manner and schedule by which an area office, separate and distinct from the Phoenix Area Office of the Service, can be established in the State of Nevada.

''(b) FAILURE TO SUBMIT PLAN.—

''(1) DEFINITION OF OPERATIONS FUNDS.—In this subsection, the term 'operations funds' means only the funds used for—

''(A) the administration of services, including functional expenses such as overtime, personnel salaries, and associated benefits; or

''(B) related tasks that directly affect the operations described in subparagraph (A).

''(2) WITHHOLDING OF FUNDS.—If the Secretary fails to submit a plan in accordance with subsection (a), the Secretary shall withhold the operations funds reserved for the Office of the Director, subject to the condition that the withholding shall not adversely impact the capacity of the Service to deliver health care services.

''(3) RESTORATION.—The operations funds withheld pursuant to paragraph (2) may be restored, at the discretion of the Secretary, to the Office of the Director on achievement by that Office of compliance with this section.''.

Subtitle G—Behavioral Health Programs

SEC. 181. BEHAVIORAL HEALTH PROGRAMS.

Title VII of the Indian Health Care Improvement Act (25 U.S.C. 1665 et seq.) is amended to read as follows:

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''Subtitle A—General Programs

''SEC. 701. DEFINITIONS.

''In this subtitle:

''(1) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS; ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system abnormalities, which may range from minor intellectual deficits and developmental delays to mental retardation. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other physical characteristics are not present in ARND, thus making diagnosis difficult.

''(2) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

''(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

''(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

''(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

''(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

''(B) INCLUSIONS.—The term 'fetal alcohol spectrum disorders' may include—

''(i) fetal alcohol syndrome (FAS);

''(ii) partial fetal alcohol syndrome (partial FAS);

''(iii) alcohol-related birth defects (ARBD); and

''(iv) alcohol-related neurodevelopmental disorders (ARND).

''(6) FAS OR FETAL ALCOHOL SYNDROME.—The term 'FAS' or 'fetal alcohol syndrome' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement, such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurological abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following:

''(i) Microophthalmia.

''(ii) Short palpebral fissures.

''(iii) Poorly developed philtrum.

''(iv) Thin upper lip.

''(v) Flat nasal bridge.

''(vi) Short upturned nose.

''(C) Prenatal or postnatal growth delay.

''(7) REHABILITATION.—The term 'rehabilitation' means medical and health care services that—

''(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

''(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

''(C) have as their purpose any of the following:

''(i) The maximum attainment of physical, mental, and developmental functioning.

''(ii) Averting deterioration in physical or mental functional status.

''(iii) The maintenance of physical or mental health functional status.

''(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''SEC. 702. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, Indian tribes, and tribal organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian tribes and tribal organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian tribes, tribal organizations, and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian tribes, tribal organizations, urban Indian organizations, and Service areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian tribe, tribal organization, urban Indian organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management;

''(I) diagnostic services; and

''(J) promotion of healthy approaches to risk and safety issues, including injury prevention.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

''(A) preschool and school age fetal alcohol spectrum disorder services, including assessment and behavioral intervention;

''(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

''(C) identification and treatment of co-occurring disorders and comorbidity;

''(D) prevention of alcohol, drug, inhalant, and tobacco use;

''(E) early intervention, treatment, and aftercare;

''(F) promotion of healthy approaches to risk and safety issues; and

''(G) identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches for risk-related behavior;

''(E) treatment services for women at risk of giving birth to a child with a fetal alcohol spectrum disorder; and

''(F) sex specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including—

''(A) early intervention, treatment, and aftercare for affected families;

''(B) treatment for sexual assault and domestic violence; and

''(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches to managing conditions related to aging;

''(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

''(F) identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian tribe, tribal organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian tribe, tribal organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may make funding available to Indian tribes and tribal organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 703. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF INTERIOR.

''(a) CONTENTS.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service unit, Service area, and headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian tribes and tribal organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

''(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

''(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 702(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian tribes and tribal organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse

among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 704. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care, and shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

''(F) diagnostic services.

''(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

''SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this section involves the use and promotion of the traditional health care practices of the Indian tribes to be served.

''SEC. 706. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''(a) IN GENERAL.—Subject to section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

''(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

''(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

''(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

''(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

''SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) GRANTS.—The Secretary, consistent with section 702, may make grants to Indian tribes, tribal organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used—

''(1) to develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol spectrum disorders;

''(2) to identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) to develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—20 percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

''SEC. 708. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 702, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(*l*) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(*l*)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may, if feasible and appropriate, incorporate systems of care, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian tribes and tribal organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian tribes, or tribal organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 702, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

''(1) the number of Indian youth who are being provided mental health services through the Service and tribal health programs;

''(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and tribal health programs;

''(3) the number of youth referred to the Service or tribal health programs for mental health services;

''(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and tribal health programs, reported separately for on- and off-reservation facilities; and

''(5) the costs of the services described in paragraph (4).

''SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

''Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 area offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 710. TRAINING AND COMMUNITY EDUCATION.

''(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian tribes and tribal organizations to develop and implement, within each Service unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol spectrum disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol abuse and other behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

''SEC. 711. BEHAVIORAL HEALTH PROGRAM.

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 702, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

''(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with traditional health care practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 712. FETAL ALCOHOL SPECTRUM DISORDERS PROGRAMS.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 702, acting through the Service, Indian tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol spectrum disorders programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

''(2) USE OF FUNDS.—

''(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

''(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol spectrum disorders.

''(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

''(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol spectrum disorders-affected Indians and their families or caretakers.

''(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-affected Indian children.

''(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

''(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol spectrum disorders.

''(vii) To develop and implement, in consultation with Indian tribes and tribal organizations, and in conference with urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers.

''(viii) To develop and provide training on fetal alcohol spectrum disorders to professionals providing services to Indians, including medical and allied health practitioners, social service providers, educators, and law enforcement, court officials and corrections personnel in the juvenile and criminal justice systems.

''(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

''(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol spectrum disorders among Indians.

''(ii) Community-based support services for Indians and women pregnant with Indian children.

''(iii) Community-based housing for adult Indians with fetal alcohol spectrum disorders.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol spectrum disorders in Indian communities; and

''(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol spectrum disorders.

''(c) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian tribes, tribal organizations, and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

''(d) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish, consistent with section 702, in every Service area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) other members of the household or family of the victims described in paragraph (1).

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

''(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and urban centers.

''(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

''SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

''(a) IN GENERAL.—The Secretary, in accordance with section 702, is authorized to establish in each Service area programs involving the prevention and treatment of—

''(1) Indian victims of domestic violence or sexual abuse; and

''(2) other members of the household or family of the victims described in paragraph (1).

''(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—

''(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

''(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

''(3) to purchase rape kits; and

''(4) to develop prevention and intervention models, which may incorporate traditional health care practices.

''(c) TRAINING AND CERTIFICATION.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

''(d) COORDINATION.—

''(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

''(A) to improve domestic violence or sexual abuse responses;

''(B) to improve forensic examinations and collection;

''(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

''(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

''SEC. 715. BEHAVIORAL HEALTH RESEARCH.

''(a) IN GENERAL.—The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes, or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the multifactorial causes of Indian youth suicide, including—

''(A) protective and risk factors and scientific data that identifies those factors; and

''(B) the effects of loss of cultural identity and the development of scientific data on those effects;

''(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(3) the development of models of prevention techniques.

''(b) EMPHASIS.—The effect of the interrelationships and interdependencies referred to in subsection (a)(2) on children, and the development of prevention techniques under subsection (a)(3) applicable to children, shall be emphasized.

''Subtitle B—Indian Youth Suicide Prevention

''SEC. 721. FINDINGS AND PURPOSE.

''(a) FINDINGS.—Congress finds that—

''(1)(A) the rate of suicide of American Indians and Alaska Natives is 1.9 times higher than the national average rate; and

''(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is—

''(i) 3.5 times the national average rate; and

''(ii) the highest rate of any population group in the United States;

''(2) many risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

''(A) history of previous suicide attempts;

''(B) family history of suicide;

''(C) history of depression or other mental illness;

''(D) alcohol or drug abuse;

''(E) health disparities;

''(F) stressful life events and losses;

''(G) easy access to lethal methods;

''(H) exposure to the suicidal behavior of others;

''(I) isolation; and

''(J) incarceration;

''(3) according to national data for 2005, suicide was the second-leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;

''(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

''(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

''(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

''(B) data demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

''(5)(A) Indian tribes, especially Indian tribes located in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

''(B) suicide clustering in Indian country affects entire tribal communities;

''(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

''(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

''(B) 90 percent of all teens who die by suicide suffer from a diagnosable mental illness at time of death;

''(C) more than ½ of teens who die by suicide have never been seen by a mental health provider; and

''(D) ⅓ of health needs in Indian country relate to mental health;

''(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

''(9) the Substance Abuse and Mental Health Services Administration and the Service have established specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

''(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

''(A) the Substance Abuse and Mental Health Services Administration;

''(B) the Service;

''(C) the Centers for Disease Control and Prevention;

''(D) the National Institutes of Health; and

''(E) the Health Resources and Services Administration; and

''(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

''(b) PURPOSES.—The purposes of this subtitle are—

''(1) to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth, including through—

''(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

''(B) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

''(C) training and related support for community leaders, family members, and health and education workers who work with Indian youth;

''(D) the development of culturally relevant educational materials on suicide; and

''(E) data collection and reporting;

''(2) to encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and

''(3) to enhance the provision of mental health care services to Indian youth through existing grant programs of the Substance Abuse and Mental Health Services Administration.

''SEC. 722. DEFINITIONS.

''In this subtitle:

''(1) ADMINISTRATION.—The term 'Administration' means the Substance Abuse and Mental Health Services Administration.

''(2) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under section 723(a).

''(3) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long-distance mental health care, patient and professional-related education, public health, and health administration.

''SEC. 723. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

''(a) AUTHORIZATION.—

''(1) IN GENERAL.—The Secretary, acting through the Service, is authorized to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who—

''(A) have expressed suicidal ideas;

''(B) have attempted suicide; or

''(C) have behavioral health conditions that increase or could increase the risk of suicide.

''(2) ELIGIBILITY FOR GRANTS.—Grants under paragraph (1) shall be awarded to Indian tribes and tribal organizations that operate 1 or more facilities—

''(A) located in an area with documented disproportionately high rates of suicide;

''(B) reporting active clinical telehealth capabilities; or

''(C) offering school-based telemental health services to Indian youth.

''(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

''(4) MAXIMUM NUMBER OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian tribes and tribal organizations that—

''(A) serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide;

''(B) enter into collaborative partnerships with Service or other tribal health programs or facilities to provide services under this demonstration project;

''(C) serve an isolated community or geographic area that has limited or no access to behavioral health services; or

''(D) operate a detention facility at which Indian youth are detained.

''(5) CONSULTATION WITH ADMINISTRATION.—In developing and carrying out the demonstration project under this subsection, the Secretary shall consult with the Administration as the Federal agency focused on mental health issues, including suicide.

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—An Indian tribe or tribal organization shall use a grant received under subsection (a) for the following purposes:

''(A) To provide telemental health services to Indian youth, including the provision of—

''(i) psychotherapy;

''(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

''(iii) alcohol and substance abuse treatment.

''(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service or tribal clinicians and health services providers working with youth being served under the demonstration project.

''(C) To assist, educate, and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under the demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among those individuals and with State and local health services providers.

''(D) To develop and distribute culturally appropriate community educational materials regarding—

''(i) suicide prevention;

''(ii) suicide education;

''(iii) suicide screening;

''(iv) suicide intervention; and

''(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

''(E) To conduct data collection and reporting relating to Indian youth suicide prevention efforts.

''(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian tribe or tribal organization may use and promote the traditional health care practices of the Indian tribes of the youth to be served.

''(c) APPLICATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), to be eligible to receive a grant under subsection (a), an Indian tribe or tribal organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the Indian tribe or tribal organization will carry out using the funds provided under the grant;

''(B) a description of the manner in which the project funded under the grant would—

''(i) meet the telemental health care needs of the Indian youth population to be served by the project; or

''(ii) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

''(C) evidence of support for the project from the local community to be served by the project;

''(D) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

''(E) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the behavioral health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

''(F) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

''(2) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under paragraph (1).

''(d) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian tribes and tribal organizations receiving grants under this section to collaborate to enable comparisons regarding best practices across projects.

''(e) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

''(1) describes the number of telemental health services provided; and

''(2) includes any other information that the Secretary may require.

''(f) REPORTS TO CONGRESS.—

''(1) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 2 years after the date on which the first grant is awarded under this section, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that—

''(i) describes each project funded by a grant under this section during the preceding 2-year period, including a description of the level of success achieved by the project; and

''(ii) evaluates whether the demonstration project should be continued during the period beginning on the date of termination of funding for the demonstration project under subsection (g) and ending on the date on which the final report is submitted under paragraph (2).

''(B) CONTINUATION OF DEMONSTRATION PROJECT.—On a determination by the Secretary under clause (ii) of subparagraph (A) that the demonstration project should be continued, the Secretary may carry out the demonstration project during the period described in that clause using such sums otherwise made available to the Secretary as the Secretary determines to be appropriate.

''(2) FINAL REPORT.—Not later than 270 days after the date of termination of funding for the demonstration project under subsection (g), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a final report that—

''(A) describes the results of the projects funded by grants awarded under this section, including any data available that indicate the number of attempted suicides;

''(B) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

''(C) evaluates whether the demonstration project should be—

''(i) expanded to provide more than 5 grants; and

''(ii) designated as a permanent program; and

''(D) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2010 through 2013.

''SEC. 724. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION GRANTS.

''(a) GRANT APPLICATIONS.—

''(1) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary, acting through the Administration, shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under any program administered by the Administration, including by providing methods other than electronic methods of submitting applications for those grants, if necessary.

''(2) PRIORITY FOR CERTAIN GRANTS.—

''(A) IN GENERAL.—To fulfill the trust responsibility of the United States to Indian tribes, in awarding relevant grants pursuant to a program described in subparagraph (B), the Secretary shall take into consideration the needs of Indian tribes or tribal organizations, as applicable, that serve populations with documented high suicide rates, regardless of whether those Indian tribes or tribal organizations possess adequate personnel or infrastructure to fulfill all applicable requirements of the relevant program.

''(B) DESCRIPTION OF GRANT PROGRAMS.—A grant program referred to in subparagraph (A) is a grant program—

''(i) administered by the Administration to fund activities relating to mental health, suicide prevention, or suicide-related risk factors; and

''(ii) under which an Indian tribe or tribal organization is an eligible recipient.

''(3) CLARIFICATION REGARDING INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Notwithstanding any other provision of law, in applying for a grant under any program administered by the Administration, no Indian tribe or tribal organization shall be required to apply through a State or State agency.

''(4) REQUIREMENTS FOR AFFECTED STATES.—

''(A) DEFINITIONS.—In this paragraph:

''(i) AFFECTED STATE.—The term 'affected State' means a State—

''(I) the boundaries of which include 1 or more Indian tribes; and

''(II) the application for a grant under any program administered by the Administration of which includes statewide data.

''(ii) INDIAN POPULATION.—The term 'Indian population' means the total number of residents of an affected State who are Indian.

''(B) REQUIREMENTS.—As a condition of receipt of a grant under any program administered by the Administration, each affected State shall—

''(i) describe in the grant application—

''(I) the Indian population of the affected State; and

''(II) the contribution of that Indian population to the statewide data used by the affected State in the application; and

''(ii) demonstrate to the satisfaction of the Secretary that—

''(I) of the total amount of the grant, the affected State will allocate for use for the Indian population of the affected State an amount equal to the proportion that—

''(aa) the Indian population of the affected State; bears to

''(bb) the total population of the affected State; and

''(II) the affected State will take reasonable efforts to collaborate with each Indian tribe located within the affected State to carry out youth suicide prevention and treatment measures for members of the Indian tribe.

''(C) REPORT.—Not later than 1 year after the date of receipt of a grant described in subparagraph (B), an affected State shall submit to the Secretary a report describing the measures carried out by the affected State to ensure compliance with the requirements of subparagraph (B)(ii).

''(b) NO NON-FEDERAL SHARE REQUIREMENT.—Notwithstanding any other provision of law, no Indian tribe or tribal organization shall be required to provide a non-Federal share of the cost of any project or activity carried out using a grant provided under any program administered by the Administration.

''(c) OUTREACH FOR RURAL AND ISOLATED INDIAN TRIBES.—Due to the rural, isolated nature of most Indian reservations and communities (especially those reservations and communities in the Great Plains region), the Secretary shall conduct outreach activities, with a particular emphasis on the provision of telemental health services, to achieve the purposes of this subtitle with respect to Indian tribes located in rural, isolated areas.

''(d) PROVISION OF OTHER ASSISTANCE.—

''(1) IN GENERAL.—The Secretary, acting through the Administration, shall carry out such measures (including monitoring and the provision of required assistance) as the Secretary determines to be necessary to ensure the provision of adequate suicide prevention and mental health services to Indian tribes described in paragraph (2), regardless of whether those Indian tribes possess adequate personnel or infrastructure—

''(A) to submit an application for a grant under any program administered by the Administration, including due to problems relating to access to the Internet or other electronic means that may have resulted in previous obstacles to submission of a grant application; or

''(B) to fulfill all applicable requirements of the relevant program.

''(2) DESCRIPTION OF INDIAN TRIBES.—An Indian tribe referred to in paragraph (1) is an Indian tribe—

''(A) the members of which experience—

''(i) a high rate of youth suicide;

''(ii) low socioeconomic status; and

''(iii) extreme health disparity;

''(B) that is located in a remote and isolated area; and

''(C) that lacks technology and communication infrastructure.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as the Secretary determines to be necessary to carry out this subsection.

''(e) EARLY INTERVENTION AND ASSESSMENT SERVICES.—

''(1) DEFINITION OF AFFECTED ENTITY.—In this subsection, the term 'affected entity' means any entity—

''(A) that receives a grant for suicide intervention, prevention, or treatment under a program administered by the Administration; and

''(B) the population to be served by which includes Indian youth.

''(2) REQUIREMENT.—The Secretary, acting through the Administration, shall ensure that each affected entity carrying out a youth suicide early intervention and prevention strategy described in section 520E(c)(1) of the Public Health Service Act (42 U.S.C. 290bb–36(c)(1)), or any other youth suicide-related early intervention and assessment activity, provides training or education to individuals who interact frequently with the Indian youth to be served by the affected entity (including parents, teachers, coaches, and mentors) on identifying warning signs of Indian youth who are at risk of committing suicide.

''SEC. 725. USE OF PREDOCTORAL PSYCHOLOGY AND PSYCHIATRY INTERNS.

''The Secretary shall carry out such activities as the Secretary determines to be necessary to encourage Indian tribes, tribal organizations, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns—

''(1) to increase the quantity of patients served by the Indian tribes, tribal organizations, and other mental health care providers; and

''(2) for purposes of recruitment and retention.

''SEC. 726. INDIAN YOUTH LIFE SKILLS DEVELOPMENT DEMONSTRATION PROGRAM.

''(a) PURPOSE.—The purpose of this section is to authorize the Secretary, acting through

the Administration, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide, including through—

''(1) the establishment of tribal partnerships to develop and implement such a curriculum, in cooperation with—

''(A) behavioral health professionals, with a priority for tribal partnerships cooperating with mental health professionals employed by the Service;

''(B) tribal or local school agencies; and

''(C) parent and community groups;

''(2) the provision by the Administration or the Service of—

''(A) technical expertise; and

''(B) clinicians, analysts, and educators, as appropriate;

''(3) training for teachers, school administrators, and community members to implement the curriculum;

''(4) the establishment of advisory councils composed of parents, educators, community members, trained peers, and others to provide advice regarding the curriculum and other components of the demonstration program;

''(5) the development of culturally appropriate support measures to supplement the effectiveness of the curriculum; and

''(6) projects modeled after evidence-based projects, such as programs evaluated and published in relevant literature.

''(b) DEMONSTRATION GRANT PROGRAM.—

''(1) DEFINITIONS.—In this subsection:

''(A) CURRICULUM.—The term 'curriculum' means the culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide identified by the Secretary under paragraph (2)(A).

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(i) an Indian tribe;

''(ii) a tribal organization;

''(iii) any other tribally authorized entity; and

''(iv) any partnership composed of 2 or more entities described in clause (i), (ii), or (iii).

''(2) ESTABLISHMENT.—The Secretary, acting through the Administration, may establish and carry out a demonstration program under which the Secretary shall—

''(A) identify a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide;

''(B) identify the Indian tribes that are at greatest risk for adolescent suicide;

''(C) invite those Indian tribes to participate in the demonstration program by—

''(i) responding to a comprehensive program requirement request of the Secretary; or

''(ii) submitting, through an eligible entity, an application in accordance with paragraph (4); and

''(D) provide grants to the Indian tribes identified under subparagraph (B) and eligible entities to implement the curriculum with respect to Indian and Alaska Native youths who—

''(i) are between the ages of 10 and 19; and

''(ii) attend school in a region that is at risk of high youth suicide rates, as determined by the Administration.

''(3) REQUIREMENTS.—

''(A) TERM.—The term of a grant provided under the demonstration program under this section shall be not less than 4 years.

''(B) MAXIMUM NUMBER.—The Secretary may provide not more than 5 grants under the demonstration program under this section.

''(C) AMOUNT.—The grants provided under this section shall be of equal amounts.

''(D) CERTAIN SCHOOLS.—In selecting eligible entities to receive grants under this section, the Secretary shall ensure that not less than 1 demonstration program shall be carried out at each of—

''(i) a school operated by the Bureau of Indian Education;

''(ii) a Tribal school; and

''(iii) a school receiving payments under section 8002 or 8003 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7702, 7703).

''(4) APPLICATIONS.—To be eligible to receive a grant under the demonstration program, an eligible entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) an assurance that, in implementing the curriculum, the eligible entity will collaborate with 1 or more local educational agencies, including elementary schools, middle schools, and high schools;

''(B) an assurance that the eligible entity will collaborate, for the purpose of curriculum development, implementation, and training and technical assistance, with 1 or more—

''(i) nonprofit entities with demonstrated expertise regarding the development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

''(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

''(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher not less frequently than twice each school week for the duration of the academic year;

''(D) a description of the methods by which curriculum participants will be—

''(i) screened for mental health at-risk indicators; and

''(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis response capability; and

''(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

''(i) drug or alcohol abuse;

''(ii) sexual or domestic abuse; and

''(iii) depression and other relevant mental health concerns.

''(5) USE OF FUNDS.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may use a grant provided under this subsection—

''(A) to develop and implement the curriculum in a school-based setting;

''(B) to establish an advisory council—

''(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

''(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

''(C) to appoint and train a school- and community-based cultural resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school administrators, and the advisory council established by the Indian tribe or eligible entity;

''(D) to establish an on-site, school-based, MA- or PhD-level mental health practitioner (employed by the Service, if practicable) to work with tribal educators and other personnel;

''(E) to provide for the training of peer counselors to assist in carrying out the curriculum;

''(F) to procure technical and training support from nonprofit or State entities or institutions of higher education identified by the community being served by the Indian tribe or eligible entity as the best suited to develop and implement the curriculum;

''(G) to train teachers and school administrators to effectively carry out the curriculum;

''(H) to establish an effective referral procedure and network;

''(I) to identify and develop culturally compatible curriculum support measures;

''(J) to obtain educational materials and other resources from the Administration or other appropriate entities to ensure the success of the demonstration program; and

''(K) to evaluate the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide.

''(c) EVALUATIONS.—Using such amounts made available pursuant to subsection (e) as the Secretary determines to be appropriate, the Secretary shall conduct, directly or through a grant, contract, or cooperative agreement with an entity that has experience regarding the development and operation of successful culturally compatible, school-based, life skills suicide prevention and intervention programs or evaluations, an annual evaluation of the demonstration program under this section, including an evaluation of—

''(1) the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

''(2) areas for program improvement; and

''(3) additional development of the goals and objectives of the demonstration program.

''(d) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the date of termination of the demonstration program, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Natural Resources and the Committee on Education and Labor of the House of Representatives a final report that—

''(A) describes the results of the program of each Indian tribe or eligible entity under this section;

''(B) evaluates the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

''(C) makes recommendations regarding—

''(i) the expansion of the demonstration program under this section to additional eligible entities;

''(ii) designating the demonstration program as a permanent program; and

''(iii) identifying and distributing the curriculum through the Suicide Prevention Resource Center of the Administration; and

''(D) incorporates any public comments received under paragraph (2).

''(2) PUBLIC COMMENT.—The Secretary shall provide a notice of the report under paragraph (1) and an opportunity for public comment on the report for a period of not less than 90 days before submitting the report to Congress.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2010 through 2014.''.

Subtitle H—Miscellaneous

SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

Title VIII of the Indian Health Care Improvement Act (as amended by section

101(b)) is amended by inserting after section 804 (25 U.S.C. 1674) the following:

"SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

''(a) DEFINITIONS.—In this section:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 119, who is—

''(A) granted clinical practice privileges or employed to provide health care services at—

''(i) an Indian health program; or

''(ii) a health program of an urban Indian organization; and

''(B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

''(2) MEDICAL QUALITY ASSURANCE PROGRAM.—The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 by or for any Indian health program or urban Indian organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian health program or urban Indian organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review, and identification and prevention of medical or dental incidents and risks.

''(3) MEDICAL QUALITY ASSURANCE RECORD.—The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that—

''(A) emanate from quality assurance program activities described in paragraph (2); and

''(B) are produced or compiled by or for an Indian health program or urban Indian organization as part of a medical quality assurance program.

''(b) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian health program or a health program of an urban Indian organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (d).

''(c) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (b) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (d).

''(2) TESTIMONY.—An individual who reviews or creates medical quality assurance records for any Indian health program or urban Indian organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

''(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (b) may be disclosed, and an individual referred to in subsection (c) may give testimony in connection with such a record, only as follows:

''(A) To a Federal agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian health program or to a health program of an urban Indian organization to perform monitoring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian health program or urban Indian organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

''(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

''(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

''(E) To an officer, employee, or contractor of the Indian health program or urban Indian organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

''(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

''(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

''(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian health program or urban Indian organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (b) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization.

''(e) DISCLOSURE FOR CERTAIN PURPOSES.—

''(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian health program or urban Indian organization's medical quality assurance programs.

''(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

''(f) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—An individual or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

''(g) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (b) may not be made available to any person under section 552 of title 5, United States Code.

''(h) LIMITATION ON CIVIL LIABILITY.—An individual who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (b) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(i) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(j) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

''(k) CONTINUED PROTECTION.—Disclosure under subsection (d) does not permit redisclosure except to the extent such further disclosure is authorized under subsection (d) or is otherwise authorized to be disclosed under this section.

''(l) INCONSISTENCIES.—To the extent that the protections under part C of title IX of the Public Health Service Act (42 U.S.C. 229b–21 et seq.) (as amended by the Patient Safety and Quality Improvement Act of 2005 (Public Law 109–41; 119 Stat. 424)) and this section are inconsistent, the provisions of whichever is more protective shall control.

''(m) RELATIONSHIP TO OTHER LAW.—This section shall continue in force and effect, except as otherwise specifically provided in any Federal law enacted after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009.''.

SEC. 192. ARIZONA, NORTH DAKOTA, AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREAS; ELIGIBILITY OF CALIFORNIA INDIANS.

Title VIII of the Indian Health Care Improvement Act is amended—

(1) by striking section 808 (25 U.S.C. 1678) and inserting the following:

"SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—The State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the State of Arizona.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if the curtailment is due to the provision of contract services in that State pursuant to the designation of the State as a contract health service delivery area by subsection (a).'';

(2) by inserting after section 808 (25 U.S.C. 1678) the following:

"SEC. 808A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—The States of North Dakota and South Dakota shall be designated

as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a contract health service delivery area by subsection (a).''; and

(3) by striking section 809 (25 U.S.C. 1679) and inserting the following:

''SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a federally recognized Indian tribe.

''(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

''(4) Any Indian of California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.''.

SEC. 193. METHODS TO INCREASE ACCESS TO PROFESSIONALS OF CERTAIN CORPS.

Section 812 of the Indian Health Care Improvement Act (25 U.S.C. 1680b) is amended to read as follows:

''SEC. 812. NATIONAL HEALTH SERVICE CORPS.

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not remove a member of the National Health Service Corps from an Indian health program or urban Indian organization or withdraw funding used to support such a member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from the member will experience no reduction in services.

''(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian health program, the services of a member of the National Health Service Corps assigned to the Indian health program may be limited to the individuals who are eligible for services from that Indian health program.''.

SEC. 194. HEALTH SERVICES FOR INELIGIBLE PERSONS.

Section 813 of the Indian Health Care Improvement Act (25 U.S.C. 1680c) is amended to read as follows:

''SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) HEALTH FACILITIES PROVIDING HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service unit and who are not otherwise eligible for such health services if—

''(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and

''(B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians.

''(2) ISDEAA PROGRAMS.—In the case of health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. The provisions of section 314 of Public Law 101–512 (104 Stat. 1959), as amended by section 308 of Public Law 103–138 (107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph.

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 207 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or children's health insurance program reimbursements under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq.), shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

''(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the Service Area revoke their concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

''(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

''(2) DEFINITION.—For purposes of this subsection, the term 'non-Service health care practitioner' means a practitioner who is not—

''(A) an employee of the Service; or

''(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.''.

SEC. 195. ANNUAL BUDGET SUBMISSION.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

''SEC. 826. ANNUAL BUDGET SUBMISSION.

''Effective beginning with the submission of the annual budget request to Congress for fiscal year 2011, the President shall include, in the amount requested and the budget justification, amounts that reflect any changes in—

''(1) the cost of health care services, as indexed for United States dollar inflation (as measured by the Consumer Price Index); and

''(2) the size of the population served by the Service.''.

SEC. 196. PRESCRIPTION DRUG MONITORING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 195) is amended by adding at the end the following:

''SEC. 827. PRESCRIPTION DRUG MONITORING.

''(a) MONITORING.—

''(1) ESTABLISHMENT.—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, tribal health care facilities, and urban Indian health care facilities.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

''(A) the needs of the Service, tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program under paragraph (1);

''(B) the planned development of that program, including any relevant statutory or administrative limitations; and

''(C) the means by which the program could be carried out in coordination with any State prescription drug monitoring program.

''(b) ABUSE.—

''(1) IN GENERAL.—The Attorney General, in conjunction with the Secretary and the Secretary of the Interior, shall conduct—

''(A) an assessment of the capacity of, and support required by, relevant Federal and tribal agencies—

''(i) to carry out data collection and analysis regarding incidents of prescription drug abuse in Indian communities; and

''(ii) to exchange among those agencies and Indian health programs information relating to prescription drug abuse in Indian communities, including statutory and administrative requirements and limitations relating to that abuse; and

''(B) training for Indian health care providers, tribal leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse and strategies for improving agency responses to addressing prescription drug abuse in Indian communities.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Attorney General shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

''(A) the capacity of Federal and tribal agencies to carry out data collection and analysis and information exchanges as described in paragraph (1)(A);

''(B) the training conducted pursuant to paragraph (1)(B);

''(C) infrastructure enhancements required to carry out the activities described in paragraph (1), if any; and

''(D) any statutory or administrative barriers to carrying out those activities.''.

SEC. 197. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 196) is amended by adding at the end the following:

''SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

''(a) IN GENERAL.—Nothing in this Act limits the ability of a tribal health program operating any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a compact with the Service pursuant to title V of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458aaa et seq.) to charge an Indian for services provided by the tribal health program.

''(b) SERVICE.—Nothing in this Act authorizes the Service—

''(1) to charge an Indian for services; or

''(2) to require any tribal health program to charge an Indian for services.''.

SEC. 198. DISEASE AND INJURY PREVENTION REPORT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 197) is amended by adding at the end the following:

''SEC. 829. DISEASE AND INJURY PREVENTION REPORT.

''Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committees on Natural Resources and Energy and Commerce of the House of Representatives describing—

''(1) all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes; and

''(2) the effectiveness of those activities, including the reductions of injury or disease conditions achieved by the activities.''.

SEC. 199. OTHER GAO REPORTS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 198) is amended by adding at the end the following:

''SEC. 830. OTHER GAO REPORTS.

''(a) COORDINATION OF SERVICES.—

''(1) STUDY AND EVALUATION.—The Comptroller General of the United States shall conduct a study, and evaluate the effectiveness, of coordination of health care services provided to Indians—

''(A) through Medicare, Medicaid, or SCHIP;

''(B) by the Service; or

''(C) using funds provided by—

''(i) State or local governments; or

''(ii) Indian tribes.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report—

''(A) describing the results of the evaluation under paragraph (1); and

''(B) containing recommendations of the Comptroller General regarding measures to support and increase coordination of the provision of health care services to Indians as described in paragraph (1).

''(b) PAYMENTS FOR CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Comptroller General shall conduct a study on the use of health care furnished by health care providers under the contract health services program funded by the Service and operated by the Service, an Indian tribe, or a tribal organization.

''(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

''(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for that health care through other public programs and in the private sector;

''(B) barriers to accessing care under such contract health services program, including barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under the program;

''(C) the adequacy of existing Federal funding for health care under the contract health services program;

''(D) the administration of the contract health service program, including the distribution of funds to Indian health programs pursuant to the program; and

''(E) any other items determined appropriate by the Comptroller General.

''(3) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations regarding—

''(A) the appropriate level of Federal funding that should be established for health care under the contract health services program described in paragraph (1);

''(B) how to most efficiently use that funding; and

''(C) the identification of any inequities in the current distribution formula or inequitable results for any Indian tribe under the funding level, and any recommendations for addressing any inequities or inequitable results identified.

''(4) CONSULTATION.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Comptroller General shall consult with the Service, Indian tribes, and tribal organizations.''.

SEC. 199A. TRADITIONAL HEALTH CARE PRACTICES.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199) is amended by adding at the end the following:

''SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.

''Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for any provision of traditional health care practices pursuant to this Act that results in damage, injury, or death to a patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or this Act.''.

SEC. 199B. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199A) is amended by adding at the end the following:

''SEC. 832. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish within the Service the position of the Director of

HIV/AIDS Prevention and Treatment (referred to in this section as the 'Director').

''(b) DUTIES.—The Director shall—

''(1) coordinate and promote HIV/AIDS prevention and treatment activities specific to Indians;

''(2) provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations regarding existing HIV/AIDS prevention and treatment programs; and

''(3) ensure interagency coordination to facilitate the inclusion of Indians in Federal HIV/AIDS research and grant opportunities, with emphasis on the programs operated under the Ryan White Comprehensive Aids Resources Emergency Act of 1990 (Public Law 101–381; 104 Stat. 576) and the amendments made by that Act.

''(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, and not less frequently than once every 2 years thereafter, the Director shall submit to Congress a report describing, with respect to the preceding 2-year period—

''(1) each activity carried out under this section; and

''(2) any findings of the Director with respect to HIV/AIDS prevention and treatment activities specific to Indians.''.

TITLE II—AMENDMENTS TO OTHER ACTS

SEC. 201. MEDICARE AMENDMENTS.

(a) IN GENERAL.—Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following:

''(f) PROHIBITION.—Payments made pursuant to this section shall not be reduced as a result of any beneficiary deductible, coinsurance, or other charge under section 1813.''.

(b) PAYMENT OF BENEFITS.—Section 1833(a)(1)(B) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(B)) is amended by inserting ''or 1880(e)'' after ''section 1861(s)(10)(A)''.

SEC. 202. REAUTHORIZATION OF NATIVE HAWAIIAN HEALTH CARE PROGRAMS.

(a) REAUTHORIZATION.—The Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is amended by striking ''2001'' each place it appears in sections 6(h)(1), 7(b), and 10(c) (42 U.S.C. 11705(h)(1), 11706(b), 11709(c)) and inserting ''2019''.

(b) HEALTH AND EDUCATION.—

(1) IN GENERAL.—Section 6(c) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11705) is amended by adding at the end the following:

''(4) HEALTH AND EDUCATION.—In order to enable privately funded organizations to continue to supplement public efforts to provide educational programs designed to improve the health, capability, and well-being of Native Hawaiians and to continue to provide health services to Native Hawaiians, notwithstanding any other provision of Federal or State law, it shall be lawful for the private educational organization identified in section 7202(16) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7512(16)) to continue to offer its educational programs and services to Native Hawaiians (as defined in section 7207 of that Act (20 U.S.C. 7517)) first and to others only after the need for such programs and services by Native Hawaiians has been met.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on December 5, 2006.

(c) DEFINITION OF HEALTH PROMOTION.—Section 12(2) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11711(2)) is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following:

''(H) educational programs with the mission of improving the health, capability, and well-being of Native Hawaiians.''.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sarah Allen, Ryan Nalty, and Grant Jamieson, staff of the Finance Committee, be granted the privilege of the floor for the duration of debate on the health care bill.

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

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sara Velde of Senator HARKIN's staff be granted the privilege of the floor during the duration of today's session.

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

DISCHARGE AND REFERRAL—S. 2129

Mr. BAUCUS. I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be discharged from further consideration of S. 2129 and the bill be referred to the Committee on Environment and Public Works.

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

SUPPORTING PEACE, SECURITY, AND INNOCENT CIVILIANS AFFECTED BY CONFLICT IN YEMEN

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 212, S. Res. 341.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 341) supporting peace, security, and innocent civilians affected by conflict in Yemen.

There being no objection, the Senate proceeded to consider the resolution.

Mr. BAUCUS. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 341) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 341

Whereas the people and Government of Yemen currently face tremendous security challenges, including the presence of a substantial number of al Qaeda militants, a rebellion in the northern part of the country, unrest in southern regions, and piracy in the Gulf of Aden;

Whereas these security challenges are compounded by a lack of governance throughout portions of the country;

Whereas this lack of governance creates a de facto safe haven for al Qaeda and militant forces in regions of Yemen;

Whereas Yemen also faces significant development challenges, reflected in its ranking of 140 out of 182 countries in the United Nations Development Program's 2009 Human Development Index;

Whereas Yemen is also confronted with limited and rapidly depleting natural resources, including oil, which accounts for over 75 percent of government revenue, and water, ⅓ of which goes to the cultivation of qat, a narcotic to which a vast number of Yemenis are addicted;

Whereas government subsidies are contributing to the depletion of Yemen's scarce resources;

Whereas the people of Yemen suffer from a lack of certain government services, including a robust education and skills training system;

Whereas the Department of State's 2009 International Religious Freedom Report notes that nearly all of the once-sizeable Jewish population in Yemen has emigrated, and, based on fears for the Jewish community's safety in the country, the United States Government has initiated a special process to refer Yemeni Jews for refugee resettlement in the United States;

Whereas women in Yemen have faced entrenched discrimination, obstacles in accessing basic education, and gender-based violence in their homes, communities, and workplaces while little is done to enforce or bolster the equality of women;

Whereas these challenges pose a threat not only to the Republic of Yemen, but to the region and to the national security of the United States;

Whereas, to the extent that Yemen serves as a base for terrorist operations and recruitment, these threats must be given sufficient consideration in the global strategy of the United States to combat terrorism;

Whereas this threat has materialized in the past, including the March 18 and September 17, 2008, attacks on the United States Embassy in Sana'a and the October 12, 2000, attack on the U.S.S. Cole while it was anchored in the Port of Aden, as well as numerous other terrorist attacks;

Whereas the population of Yemen has suffered greatly from conflict and underdevelopment in Yemen;

Whereas up to 150,000 civilians have fled their homes in northern Yemen since 2004 in response to conflict between Government of Yemen forces and al-Houthi rebel forces; and

Whereas the people and Government of the United States support peace in Yemen and improved security, economic development, and basic human rights for the people of Yemen: Now, therefore, be it

Resolved, That the Senate—

(1) supports the innocent civilians in Yemen, especially displaced persons, who have suffered from instability, terrorist operations, and chronic underdevelopment in Yemen;

(2) recognizes the serious threat instability and terrorism in Yemen pose to the security of the United States, the region, and the population in Yemen;

(3) calls on the President to give sufficient weight to the situation in Yemen in efforts to prevent terrorist attacks on the United States, United States allies, and Yemeni civilians;

(4) calls on the President to promote economic and political reforms necessary to advance economic development and good governance in Yemen;

(5) applauds steps that have been taken by the President and the United Nations High Commissioner for Refugees to assist displaced persons in Yemen;

(6) urges the Government of Yemen and rebel forces to immediately halt hostilities, allow medical and humanitarian aid to reach civilians displaced by conflict, and create an environment that will enable a return to normal life for those displaced by the conflict; and

(7) calls on the President and international community to use all appropriate measures to assist the people of Yemen to prevent Yemen from becoming a failed state.

RELATIVE TO THE DEATH OF FORMER SENATOR PAULA F. HAWKINS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 370, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 370) relative to the death of Paula F. Hawkins, former United States Senator for the State of Florida.

There being no objection, the Senate proceeded to consider the resolution.

Mr. LEMIEUX. Mr. President, I rise to express my sorrow at the passing of former U.S. Senator Paula Hawkins and to pay tribute to her long life and groundbreaking career of public service.

A resident of central Florida, Paula Hawkins began her political career in 1972 when she was elected to Florida's Public Services Commission where she served for two consecutive terms and worked to become a vibrant voice for consumers.

Paula Hawkins aspired to continue her public service by running for higher office, first for the U.S. Senate in 1974, and then for Lieutenant Governor in 1978. Though both times she lost the race, she never gave up and never lost the desire to continue working for Floridians.

Paula made history in 1980 when she became the first woman from Florida to be elected to the U.S. Senate and the first woman from Florida to be elected to Federal office.

During her tenure in the Senate, Senator Hawkins became an outspoken champion for America's victimized children and brought a special focus to the problem of child abduction. Driven by the disappearance of 6-year-old Florida resident Adam Walsh, Senator Hawkins ushered passage of landmark legislation focusing on the issue of missing children. Her work would ultimately help to establish the National Center for Missing & Exploited Children. She also supported a special unit at the Federal Bureau of Investigation that would focus solely on profiling serial killers.

Though I am saddened by her passing, I am honored today to serve in the same class as Senator Hawkins—a seat she held before being succeeded by former Senator Bob Graham, and my predecessor, Senator Mel Martinez.

The citizens of our United States owe a debt of gratitude to this great Floridian and we shall not soon forget the work of Senator Hawkins.

Mr. BAUCUS. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table.

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

The resolution (S. Res. 370) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 370

Whereas Paula F. Hawkins was a staunch consumer advocate and served the citizens of the State of Florida on its Public Service Commission for seven years, serving as its Chairman for three years;

Whereas Paula F. Hawkins was instrumental in passing the Missing Children's Assistance Act of 1984 and worked to help establish the National Center for Missing and Exploited Children;

Whereas Paula F. Hawkins served the people of Florida with distinction for 6 years in the United States Senate;

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable Paula F. Hawkins, former member of the United States Senate.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable Paula F. Hawkins.

ORDERS FOR SATURDAY, DECEMBER 5, 2009

Mr. BAUCUS. I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. on Saturday, December 5; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, with the first 3 hours following any leader remarks equally divided between the two leaders or their designees and controlled in 45-minute alternating blocks of time, with the majority controlling the first block, and with no other motions or amendments in order during the controlled time.

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

PROGRAM

Mr. BAUCUS. Mr. President, Senators should expect rollcall votes tomorrow afternoon. There will be no rollcall votes prior to 1 p.m.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BAUCUS. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the provisions of S. Res. 370, as a further mark of respect to the memory of the late Paula Hawkins, a former Senator from the State of Florida.

Thereupon, the Senate, at 6:50 p.m., adjourned until Saturday, December 5, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF TRANSPORTATION

DAVID L. STRICKLAND, OF GEORGIA, TO BE ADMINISTRATOR OF THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, VICE NICOLE R. NASON, RESIGNED.

TENNESSEE VALLEY AUTHORITY

WILLIAM B. SANSOM, OF TENNESSEE, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY FOR A TERM EXPIRING MAY 18, 2014. (REAPPOINTMENT)

DEPARTMENT OF STATE

JUDITH ANN STEWART STOCK, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF STATE (EDUCATIONAL AND CULTURAL AFFAIRS), VICE GOLI AMERI, RESIGNED.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be major general

BRIG. GEN. MARY A. LEGERE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. THOMAS P. BOSTICK

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. ROBERT L. CASLEN, JR.