not be considered to be a hazardous substance, pollutant, or contaminant.

S. 821

At the request of Mr. SMITH, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 821, a bill to amend section 402 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide for an extension of eligibility for supplemental security income through fiscal year 2010 for refugees, asylees, and certain other humanitarian immigrants.

S. 831

At the request of Mr. DURBIN, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. 831, a bill to authorize States and local governments to prohibit the investment of State assets in any company that has a qualifying business relationship with Sudan.

S. 844

At the request of Mrs. FEINSTEIN, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 844, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 849

At the request of Mr. LEAHY, the names of the Senator from Pennsylvania (Mr. SPECTER), the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 849, a bill to promote accessibility, accountability, and openness in Government by strengthening section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act), and for other purposes.

S. 852

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 852, a bill to deauthorize the project for navigation, Tenants Harbor, Maine.

S. 853

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 853, a bill to deauthorize the project for navigation, Northeast Harbor, Maine.

S. 854

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 854, a bill to modify the project for navigation, Union River, Maine.

S. 855

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 855, a bill to deauthorize a certain portion of the project for navigation, Rockland Harbor, Maine.

S. 856

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 856, a bill to terminate authorization for the project for navigation, Rockport Harbor, Maine.

S. 857

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 857, a bill to redesignate the project for navigation, Saco River, Maine, as an anchorage area.

S. 882

At the request of Mr. MENENDEZ, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 882, a bill to require a pilot program on the facilitation of the transition of members of the Armed Forces to receipt of veterans health care benefits upon completion of military service, and for other purposes.

S.J. RES. 5

At the request of Mr. DURBIN, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S.J. Res. 5, a joint resolution proclaiming Casimir Pulaski to be an honorary citizen of the United States posthumously.

S. RES. 65

At the request of Mr. BIDEN, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. Res. 65, a resolution condemning the murder of Turkish-Armenian journalist and human rights advocate Hrant Dink and urging the people of Turkey to honor his legacy of tolerance.

S. RES. 95

At the request of Mr. SPECTER, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. Res. 95, a resolution designating March 25, 2007, as ''Greek Independence Day: A National Day of Celebration of Greek and American Democracy''.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself, Mr. COBURN, Mr. LEAHY, Mr. CORNYN, and Mr. FEINGOLD):

S. 888. A bill to amend section 1091 of title 18, United States Code, to allow the prosecution of genocide in appropriate circumstances; to the Committee on the Judiciary.

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

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

S. 888

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Genocide Accountability Act of 2007''.

SEC. 2. GENOCIDE.

Section 1091 of title 18, United States Code, is amended by striking subsection (d) and inserting the following:

''(d) REQUIRED CIRCUMSTANCE FOR OFFENSES.—The circumstance referred to in subsections (a) and (c) is that—

''(1) the offense is committed in whole or in part within the United States;

''(2) the alleged offender is a national of the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(3) the alleged offender is an alien lawfully admitted for permanent residence in the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(4) the alleged offender is a stateless person whose habitual residence is in the United States; or

''(5) after the conduct required for the offense occurs, the alleged offender is brought into, or found in, the United States, even if that conduct occurred outside the United States.''.

Mr. COBURN. Mr. President, I rise today as the lead Republican sponsor of the Genocide Accountability Act of 2007. I thank my colleague, Senator DURBIN, for introducing this important piece of legislation.

Senator DURBIN serves as the chairman and I serve as the ranking member of the new Subcommittee on Human Rights and the Law in the Senate Judiciary Committee. We held our first hearing, entitled ''Genocide and the Rule of Law,'' on February 5, 2007. There could not be a more appropriate way to begin examining the law as it relates to human rights than to determine what we can and must do to prevent and stop genocide. The United States is a signatory of the Convention on the Prevention and Punishment of the Crime of Genocide. This convention provides that the contracting parties must ''undertake to prevent and to punish'' the crime of genocide. We have also passed a law implementing the Genocide Convention.

However, our hearing demonstrated that there are changes that need to be made in law and foreign policy to respond to the ongoing genocide in Sudan and to any genocide that may occur elsewhere in the future. Fortunately, two of these changes can be accomplished right now.

The first change can be accomplished through a bill Senators DURBIN and CORNYN introduced last week, of which I am a cosponsor. That bill, the Sudan Divestment Authorization Act of 2007, will allow State and local governments to prohibit the investment of State assets in the Government of Sudan or companies with certain business relationships with Sudan, while the Government of Sudan is subject to sanctions under U.S. law. The second change can be accomplished through the bill we are introducing today, the Genocide Accountability Act of 2007. This act will ensure that our justice system has the authority to prosecute someone who has committed genocide if that person is found or brought into the United States.

Under current law, the United States can deny admission to and exclude aliens from the United States on human rights grounds. The Attorney General can also consider avenues for the prosecution of aliens who have committed certain crimes, including genocide. However, the Attorney General can only prosecute a perpetrator of genocide if he committed his crimes within the United States or is a U.S. national.

What does this mean? It means that if a person who plans or participates in the genocide occurring right now in Darfur travels to the United States on vacation, business, or even to live here for an extended period of time—as a refugee or student, for instance—a court in the United States cannot touch him. The best our justice system can do is deport him once his crime is discovered.

Without question, it may be more appropriate in some cases to extradite someone who commits genocide to his home country or turn him over to an international tribunal. However, there are also times when a person's home country may not be willing to prosecute him and there is no viable alternative for prosecution. In these cases, extraditing a criminal would be no different than setting him free. This bill will not force our justice system to prosecute those who commit genocide just because they are found on our soil—it simply gives us the option. Nonetheless, in America we are blessed with great resources and the most effective and just legal system in the world. With these blessings comes great responsibility. It is contrary to our system of justice to allow perpetrators of genocide to go free without fear of prosecution.

It simply makes no sense to withhold from our justice system the authority to prosecute someone who is found in the United States and who committed a crime as atrocious as genocide just because he is not American and did not commit the crime here. We have passed tough laws that ensure that we can prosecute anyone found in the United States who has committed terrorist acts or supports terrorism. We do not want to become a safe haven for terrorists, so I ask: Do we want to be a safe haven for those who have committed genocide? The answer should be clear.

Fundamentally, we must decide if genocide is a bad enough crime, no matter where it happens, that it warrants the same treatment as terrorism-related crimes. I deeply believe that it is, and that is why I am proud to cosponsor this bill today.

By Mr. INOUYE (for himself, Mr. STEVENS, Mr. ROBERTS, and Mr. HAGEL):

S. 890. A bill to provide for certain administrative and support services for the Dwight D. Eisenhower Memorial Commission, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. INOUYE. Mr. President, the Eisenhower Memorial Commission was created by the U.S. Congress in 1999 as a bipartisan commission for the purpose of considering and formulating plans for the location, design and construction of a permanent memorial to President Dwight D. Eisenhower to perpetuate his memory and his contributions to the United States. Since being fully appointed in 2001, the Commission considered twenty-six different sites in the District of Columbia. In 2005, it selected a site between the Department of Education and the National Air and Space Museum, two institutions resulting from and greatly influenced by President Eisenhower's leadership.

In 2006, Congress approved the memorial's location within Area I, in compliance with the Commemorative Works Act. The Commission secured full approval for the selected site following extensive review by the National Park Service, the National Capital Memorial Advisory Commission, the National Capital Planning Commission, and the Commission of Fine Arts. Since its inception, the Commission has also taken great care to study and analyze President Eisenhower's legacy. It produced a report by leading scholars and experts on President Eisenhower that provides a definitive statement on the transcending elements of President Eisenhower's enduring legacy. He ranks as one of the preeminent figures in the global history of the 20th century.

The Eisenhower Memorial Commission now needs to move into the design phase. As design begins, the Commission's organization, specifically with regard to contracting and staffing, needs to be updated and revised to enable efficient management and responsible stewardship. The proposed legislation which I introduce today provides for the necessary reorganization. I am joined by Senators STEVENS, ROBERTS, and HAGEL as original cosponsors of the bill.

The legislation enables the Commission to retain the services of full, part-time, and volunteer staff as government employees, without the restrictions of the competitive service requirements. It also provides the authority for the Commission's Executive Architect to manage technical and administrative aspects of design and construction. It provides for staff to be released on the completion of the memorial and enables the Commission to work in collaboration with federal agencies.

President Eisenhower spent his entire life in public service. His extraordinary contributions include serving as Supreme Commander of the Allied Expeditionary Forces in World War II and as 34th President of the United States, but President Eisenhower also served as the first commander of NATO and as President of Columbia University. Dramatic changes occurred in America during his lifetime, many of which he participated in and influenced through his extraordinary leadership as President.

Although President Eisenhower grew up before automobiles existed, he created the Interstate Highway System and took America into space. He created the National Aeronautics and Space Administration, the Department of Health, Education, and Welfare, and the Federal Aviation Administration. He added the State of Hawaii and the State of Alaska to the United States and ended the Korean War. President Eisenhower desegregated the District of Columbia and sent Federal troops into Little Rock, Arkansas, to enforce school integration. He defused international crises and inaugurated the national security policies that guided the nation for the next three decades, leading to the peaceful end of the Cold War.

A career soldier, President Eisenhower championed peace, freedom, justice and security, and, as President, he stressed the interdependence of those goals. He spent a lifetime fulfilling his duty to his country, always remembering to ask: What is best for America?

President Eisenhower once said, ''I know that the American people share my belief that if a danger exists in the world, it is a danger shared by all; and equally, that if hope exists in the mind of one nation, that hope should be shared by all.'' President Eisenhower's legacy provides hope to all of us—like him, through education and public service, we, as a nation and individually, can rise to meet any challenge. Accordingly, I urge my colleagues to support this legislation.

I ask unanimous consent that the text of my bill be printed in the RECORD.

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

S. 890

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

SECTION 1. DWIGHT D. EISENHOWER MEMORIAL COMMISSION.

Section 8162 of the Department of Defense Appropriations Act, 2000 (Public Law 106–79; 113 Stat. 1274) is amended—

(1) by striking subsection (j), and inserting the following:

''(j) POWERS OF THE COMMISSION.—

''(1) IN GENERAL.—

''(A) POWERS.—The Commission may—

''(i) make such expenditures for services and materials for the purpose of carrying out this section as the Commission considers advisable from funds appropriated or received as gifts for that purpose;

''(ii) solicit and accept contributions to be used in carrying out this section or to be used in connection with the construction or other expenses of the memorial;

''(iii) hold hearings and enter into contracts;

''(iv) enter into contracts for specialized or professional services as necessary to carry out this section; and

''(v) take such actions as are necessary to carry out this section.

''(B) SPECIALIZED OR PROFESSIONAL SERVICES.—Services under subparagraph (A)(iv) may be—

''(i) obtained without regard to the provisions of title 5, United States Code, including section 3109 of that title; and

''(ii) may be paid without regard to the provisions of title 5, United States Code, including chapter 51 and subchapter III of chapter 53 of that title;

''(2) GIFTS OF PROPERTY.—The Commission may accept gifts of real or personal property to be used in carrying out this section, including to be used in connection with the construction or other expenses of the memorial.

''(3) FEDERAL COOPERATION.—To ensure the overall success of the efforts of the Commission, the Commission may call upon any Federal department or agency to assist in and give support to the Commission. The head of each Federal department or agency shall furnish such information or assistance requested by the Commission, as appropriate, unless prohibited by law.

''(4) POWERS OF MEMBERS AND AGENTS.—

''(A) IN GENERAL.—If authorized by the Commission, any member or agent of the Commission may take any action that the Commission is authorized to take under this section.

''(B) ARCHITECT.—The Commission may appoint an architect as an agent of the Commission to—

''(i) represent the Commission on various governmental source selection and planning boards on the selection of the firms that will design and construct the memorial; and

''(ii) perform other duties as designated by the Chairperson of the Commission.

''(C) TREATMENT.—An authorized member or agent of the Commission (including an individual appointed under subparagraph (B)) providing services to the Commission shall be considered an employee of the Federal Government in the performance of those services for the purposes of chapter 171 of title 28, United States Code, relating to tort claims.

''(5) TRAVEL.—Each member of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.'';

(2) by redesignating subsection (o) as subsection (q); and

(3) by adding at the end the following:

''(o) STAFF AND SUPPORT SERVICES.—

''(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director appointed by the Commission to be paid at a rate not to exceed the maximum rate of basic pay for level IV of the Executive Schedule.

''(2) STAFF.—

''(A) IN GENERAL.—The staff of the Commission may be appointed and terminated without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title, relating to classification and General Schedule pay rates, except that an individual appointed under this paragraph may not receive pay in excess of the maximum rate of basic pay for GS–15 of the General Schedule.

''(B) SENIOR STAFF.—Notwithstanding subparagraph (A), not more than 3 staff employees of the Commission (in addition to the Executive Director) may be paid at a rate not to exceed the maximum rate of basic pay for level IV of the Executive Schedule

''(3) STAFF OF FEDERAL AGENCIES.—Upon request by the Chairperson of the Commission, the Vice-Chairperson, or the Executive Director, the head of any Federal department or agency may detail, on a nonreimbursable basis, any of the personnel of the department or agency to the Commission to assist the Commission to carry out its duties under this section.

''(4) FEDERAL SUPPORT.—The Commission shall obtain administrative and support services from the General Services Administration on a reimbursable basis. The Commission may use all contracts, schedules, and acquisition vehicles allowed to external clients through the General Services Administration.

''(5) COOPERATIVE AGREEMENTS.—The Commission may enter into cooperative agreements with Federal agencies, State, local, tribal and international governments, and private interests and organizations which will further the goals and purposes of this section.

''(6) TEMPORARY, INTERMITTENT, AND PART-TIME SERVICES.—

''(A) IN GENERAL.—The Commission may obtain temporary, intermittent, and part-time services under section 3109 of title 5, United States Code, at rates not to exceed the maximum annual rate of basic pay payable under section 5376 of that title.

''(B) NON-APPLICABILITY TO CERTAIN SERVICES.—This paragraph shall not apply to services under subsection (j)(1)(A)(iv).

''(7) VOLUNTEER SERVICES.—

''(A) IN GENERAL.—Notwithstanding section 1342 of title 31, United States Code, the Commission may accept and utilize the services of volunteers serving without compensation.

''(B) REIMBURSEMENT.—The Commission may reimburse such volunteers for local travel and office supplies, and for other travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code.

''(C) TREATMENT.—A person providing volunteer services to the Commission shall be considered an employee of the Federal government in the performance of those services for the purposes of—

''(i) chapter 81 of title 5, United States Code, relating to compensation for work-related injuries;

''(ii) chapter 171 of title 28, United States Code, relating to tort claims; and

''(iii) chapter 11 of title 18, United States Code, relating to conflicts of interest.

''(p) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as necessary to carry out this section.''.

By Mr. INHOFE (for himself and Mr. COBURN):

S. 891. A bill to protect children and their parents from being coerced into administering a controlled substance in order to attend school, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. INHOFE. Mr. President, I rise today, along with my colleague, TOM COBURN, to proudly reintroduce the Child Medication Safety Act, a bill to protect children and their parents from being coerced into administering a controlled substance or psychotropic drug in order to attend a school.

Parents today face many challenges when raising their children, one of which is ensuring that their children receive the best education possible. My views on education come from a somewhat unique perspective in that my wife, Kay, was a teacher at Edison High School in Tulsa for many years and now both of our daughters are teachers. I can assure you that I am one of the strongest supporters of quality education. However, it has come to my attention that schools have been acting as physicians or psychologists by strongly suggesting that children with behavioral problems be put immediately on some form of psychotropic drugs. Schools and teachers are not equipped to make this diagnosis and should not make it mandatory for the student to continue attending the school. This is clearly beyond their area of expertise. Therefore, I am introducing this legislation to ensure that parents are not required by school personnel to medicate their children.

The Child Medication Safety Act requires, as a condition of receiving funds from the Department of Education, that States develop and implement polices and procedures prohibiting school personnel from requiring a child to obtain a prescription as a condition of attending the school. It should be noted that this bill does not prevent teachers or other school personnel from sharing with parents or guardians classroom-based observations regarding a student's academic performance or regarding the need for evaluation for special education. Additionally, this bill calls for a study by the Comptroller General of the United States reviewing: (1) the variation among States in the definition of psychotropic medication as used in public education, (2) the prescription rates of medication used in public schools to treat children with attention deficit disorder and other such disorders, 3) which medications listed under the Controlled Substances Act are being prescribed to such children, and 4) which medications not listed under the Controlled Substances Act are being used to treat these children and their properties and effects. This GAO report is due no later than one year after the enactment of this Act.

I believe this is an extremely important bill that protects the rights of our children against improper intrusion regarding health issues by those not qualified. If a parent or guardian believes their child is in need of medication, then they have the right to make that decision and consult with a licensed medical practitioner who is qualified to prescribe an appropriate drug. Please join us in support of this legislation that protects the freedoms of our children.

By Mr. INHOFE:

S. 892. A bill to amend the Internal Revenue Code of 1986 to provide for the indexing of certain assets for purposes of determining gain or loss; to the Committee on Finance.

Mr. INHOFE. Mr. President, I rise today to introduce the Capital Gains Inflation Relief Act of 2007. The taxation of inflation is one of the most unjust practices of the tax code. This simple improvement will not only enhance the basic fairness and efficiency of the tax code, but will also immediately increase the net return on capital investment.

Under current law, a taxable capital gain occurs whenever a capital asset is sold at a price higher than the original purchase price. However, the timing of capital gains taxation sets it apart from other types of income. While wages are generally taxed on a yearly basis, the taxation on capital assets occurs at the time the capital asset holder chooses to sell his asset and realize

his gains. The gains on capital assets accrue over the course of the asset's life, which is usually many years. This is generally favorable to the capital asset holder, because he can defer taxation on his gains to a future year. This tax deferral is often cited as the primary reason for holding assets long term.

However, the value of tax deferral is often times overstated because current tax policy taxes the capital asset holder not only on real gains, but also on gains due to inflation. This creates a situation that is patently unfair to the American taxpayer. For example, an American who purchased a share of stock for $10 in 1950 and sold it for twice that amount today would be subject to capital gains taxes on the nominal gain of $10, though the transaction was a clear loss when one accounts for inflation. Why should an American taxpayer, who invested in a capital asset in his youth, be forced to pay capital gains taxes, on what can only be viewed as a loss, in his later years? In spite of all our efforts to curb inflation, it will remain a fact of life. This does not mean we should tax hard-working Americans with long-term goals on gains that are due to inflation, gains that they will never actually realize.

Without an inflation index, the tax code incentivizes short-term speculation and discourages long-term capital investment. The current turmoil in the subprime lending market is an example that demonstrates the perils of emphasizing short-term speculation over long-term capital investment. Though inflation has remained relatively modest recently, there is no guarantee of future stability. Inflation indexing would instantly increase the net return on capital investment and consequently encourage more of it. Inflation indexing would also restore core principles of sound tax policy such as ''horizontal equity,'' wherein two taxpayers in identical situations are treated identically by the tax system. Indexing capital gains would improve the basic fairness of the tax code with only a minor increase in administrative costs and a single step of simple multiplication for taxpayer compliance.

The need for indexing is clear. It would help average Americans and improve tax policy by enhancing both the basic fairness and the pro-growth incentive of the tax code. The merits of the capital gains tax are themselves debatable, but if we are to tax capital gains let us make sure they are taxed fairly. Please join with me in supporting this legislation to free the American taxpayer from the unfairness of the current tax policy.

By Mrs. CLINTON:

S. 895. A bill to amend titles XIX and XXI of the Social Security Act to ensure that every child in the United States has access to affordable, quality health insurance coverage, and for other purposes; to the Committee on Finance.

Mrs. CLINTON. Mr. President, I was proud to help create the State Children's Health Insurance Program during the Clinton Administration. It has provided health insurance for 6 million children, including more than 425,000 in New York. SCHIP was the biggest expansion in providing health insurance coverage in more than 30 years—a big first step to providing quality health care coverage for all children.

And now it is time to take the next step. Today, I am introducing new legislation with my colleague from the House of Representatives, Chairman DINGELL: a plan to make quality affordable health care available to every child in America.

The Children's Health First Act will make quality, affordable health care available to all children, and will pave the way to cover the more than nine million children in our country without health coverage.

Our bill cuts red tape to allow States to provide affordable healthcare options for all families to cover their children. It gives States the financial incentives and resources to expand—existing State coverage and find and enroll the 6 million children who are currently eligible for health coverage but are not enrolled. And it provides incentives to expand employer sponsored coverage for children.

As individuals and as a Nation, an ounce of prevention is truly worth a pound of cure. Health care accessible and affordable for all children will keep kids healthy, save lives, control costs, and end heartache and worry for so many parents. This plan is practical and fiscally responsible—it will honor our values and prevent kids from needing more costly healthcare in the future.

Our bill will provide incentives for States to expand SCHIP to more children and provide health coverage for children up to 400 percent of poverty, about $70,000 for a family of three.

Parents whose incomes are above their State's SCHIP eligibility levels and employers who want to provide coverage to dependents will also have the option to buy-in to the SCHIP program. This will ensure that all families have access to affordable coverage and aren't forced into the private insurance market where affordable options for their children are often out of reach.

And while expanding coverage is critical, enrolling children who are already eligible must also be part of our efforts to ensure every child has health insurance.

Currently, there are 6 million uninsured children who are eligible for public programs but not enrolled. In order to receive expanded Federal funding under our bill, States must undertake strategies designed to enhance outreach and enrollment of currently eligible children.

In addition, the Children's Health First Act would prevent funding shortfalls like those that 14 States are currently facing. Unlike the original SCHIP bill our legislation would determine funding based on State spending and indexed to medical inflation and child population growth so that states will get the funds they need.

Every child deserves a healthy start in life. This goes to the heart of our values, our responsibility to one another, the promise of our country. Far too many children in our Nation—more than 9 million—do not have health care. And, for the first time in nearly a decade, between 2004 and 2005, the number of uninsured children in New York increased by 61,000—part of a trend nationally.

It's simply wrong that there are working parents who worry about their children playing sports because they can't afford a doctor if their child gets hurt. I've met parents who when their children get sick fret and worry about their children's illness—but have the added anxiety of wondering how they are going to pay for the doctor visit. That just shouldn't happen.

No child in America, the greatest, richest Nation on Earth home to so much promise, should lack for the care he or she needs to grow up to be a healthy, happy adult.

We can tackle this challenge—and provide access to quality, affordable health care for all children in America. It's the right thing to do, and it's the smart thing to do.

I am proud to introduce this legislation. It will help us honor our values, protect our children. We can meet this challenge and that's what I'll be working with Chairman DINGELL and my Senate colleagues to achieve this year.

By Ms. MURKOWSKI (for herself, Mr. SCHUMER, Mr. STEVENS, and Mr. SANDERS):

S. 896. A bill to amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and medical residents serving health professional shortage areas, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Ms. MURKOWSKI. Mr. President, I rise again this evening to speak about a growing crisis in rural America. This crisis is found in rural New England, throughout Appalachia, spans the Great Plains, crosses the Western deserts, and reaches the mountains of the great Northwest. It impacts the seniors, children, the women, and the men of rural America. What I am speaking about today is a lack of access to quality health care.

In rural America, patients have long gone without care. Despite the fact that one-fifth of the U.S. population lives in rural America, only 9 percent of the Nation's physicians are practicing in these areas. Over 50 million of these rural Americans live in areas that have a shortage of physicians to meet their basic needs.

Now, physician recruitment to rural America is a big problem. Part of this problem comes about through high student debt, which often forces many students away from a rural practice and

into urban specialty medicine where they can probably command higher salaries.

I recently held a Senate HELP Committee field hearing in Alaska. This was during the February recess. I held this field committee hearing on the physician shortage crisis in rural America. At that hearing, I had a young woman come up and speak. She is a medical student who is currently part of the WAMI Program, the Western States medical program. This young woman, Melissa Howell, is 26 years old. She stated the student debt she has accumulated is a huge concern that hangs over the decisions she makes as she decides where she is going to practice. Simply put, she said that the $100,000 student debt she faces is ''kind of scary.'' I have to admit, that is kind of scary.

A dozen States already report severe physician shortages. These shortages exist in the areas of cardiology, radiology, neurology, to name a few. But the greatest shortages persistently have been in primary care. In fact, the shortage of primary care physicians in rural areas of the United States represents one of the most intractable health policy problems of the past century.

It will only worsen. In 20 years, 20 percent of the U.S. population will be 65 or older, and this is a percentage larger than at any other time in our Nation's history. Just as this aging population places the highest demand on our health care system, we have some experts who predict a national shortage of close to 200,000 physicians. If that becomes a reality, 84 million patients could be potentially left without a doctor's care.

So the question has to be asked, where are the doctors going? We are losing some of our doctors through attrition. One-third of physicians are 55 years old and older and are likely to retire as this baby boom generation moves into its time of greatest medical need. Additionally, for the last quarter of a century, medical schools have kept their student enrollments virtually flat.

We are also losing a lot of our doctors, quite simply, through frustration. Low Medicare and Medicaid reimbursement rates, coupled with complex regulations and paperwork, leave physicians aggravated, leave them disappointed with the practice of medicine.

In Alaska, we have lived with provider shortages since statehood. I grew up in a part of the State down in the southeastern area where you did not have doctors who were available to deliver babies except on Tuesdays and Thursdays. You hoped you could give birth on a Tuesday or a Thursday. Still, in many parts of our State, we do not have providers who can deliver. If you are out in the Aleutian chain, you are told by your physician's attendant to come to Anchorage, some 600 miles away, to wait out the remaining month of your pregnancy because they do not have the facilities, do not have the doctors available to take care of you in the event of an emergency.

So we have lived with provider shortages for a long time. Because our State is larger than Texas and California and Montana combined, ''rural'' brings on a new meaning and the physician shortage crisis is even more amplified, as I have given in my two examples. But we have had some recent events in the State that have created a situation far worse than Alaska has known in the past. Currently, in the State, we have the sixth lowest ratio of physicians to population in the United States. That is when you take into account Anchorage, which is our largest population center. In rural Alaska, it is the worst physician-to-population situation in the Nation. Alaska needs nearly 400 more doctors to provide the same level of care as elsewhere in the country.

One of our problems is we do not have a medical school, and we are not likely to be getting a medical school in the near future. We also have the lowest per capita number of medical school slots in the country and the lowest number of residency slots. We have two small but very successful programs; this is the University of Washington Medical School Partnership and the Alaska Family Residency Program. These two programs help train Alaskans as physicians and also help us bring doctors to Alaska. But despite the success of these programs, each is far too small to meet our population's needs.

Each week, without fail, I receive faxes, phone calls, letters, and e-mails from Alaskan seniors who simply cannot find a doctor to treat them. I wish to read a few excerpts from recent e-mails we have received. The first one is from a gentleman in Anchorage. Keep in mind, Anchorage is our largest population center; about half the population of the State is here.

He writes:

> My mother . . . has had difficulty in the extreme in getting a doctor who will take her on as she is a medicare patient . . . doctors are telling potential patients that they are no longer taking medicaid. My mother has made in excess of 100 calls to physicians in Anchorage.

Another constituent writes—and this is also from Anchorage:

> During the past year, I've tried to find a doctor that accepts Medicare. I used the Anchorage Yellow pages and called over 100 doctors, only to be told that they won't accept any more Medicare patients.

She then writes to say:

> I'll tell you ahead of time, we'll be going to the hospital emergency rooms, to receive, even the basic medical care, i.e.: colds, flu, and other basic medical care, that could have been treated through seeing a doctor, at their established practice. This doesn't sound like good fiscal management.

Another constituent—and this was actually in a letter to the editor in the Anchorage Daily News—says:

> My friends telephoned more than 80 doctors recently, and not one was accepting new Medicare patients.

A third gentleman from Kenai, AK, writes:

> My mom has Medicare and she had to wait 5 months to be seen by a Neurologist because she had been put on a waiting list to be seen due to the fact she was a Medicare patient.

Another woman from Anchorage says:

> I just got through trying to find a physician for an elderly Medicare-dependent friend. At this time I have found no one who will take her. Most physicians take no Medicare patients or have a quota which is full. The Providence health care provider list has no one who takes Medicare.

The last e-mail was from Anchorage stating:

> Almost no family practice office in Anchorage is accepting new Medicare patients.

This is just a sample of what we get from constituents around the State of Alaska saying: I don't have anyone who can see my mother. I can't get in to see anyone myself.

I mentioned in my comments this is a crisis that is growing. In Alaska, we don't often think of it as being a State where we have a large senior population. We think of some of the Southern States as being the ones that attract our seniors. But the fact is Alaska has the second fastest-growing senior population in the Nation, second only to Nevada.

So again we ask the question: Why aren't Alaska's doctors able to provide care to our seniors? Why are they saying: No, we are not accepting any new Medicare patients? Well, a lot of it has to do with the reimbursement rates. Recent Federal reductions in Alaska Medicare reimbursement rates have been so severe that primary care physicians report that Medicare pays them only 37 cents—it is actually between 37 cents to 40 cents—for every dollar that it costs to treat a patient. So the doctor is spending a dollar in the care provided but is getting reimbursed about 40 cents to every dollar. We had one physician testify at the field hearing, and he said that in order for him to basically break even with his medical practice, he would have to see one Medicare patient every 7 minutes in order for him not to lose money. For those of us who go into our doctor's office, if we only had 7 minutes in there with our medical provider, I don't think we would feel we were getting the care and the attention our medical issues deserve.

Losing money by seeing Medicare patients has meant that many of our physicians have stopped accepting Medicare patients entirely. They are making a decision not to accept any new Medicare patients. Or if you have been a patient of a particular physician and you turn 65, you may have had a good relationship with that physician, but if he tells you: I am sorry, I am not accepting any new Medicare patients, that date of your birthday comes and all of a sudden you don't have the care that you had relied on for some period of time.

During this committee field hearing, we had testimony that revealed that

only one neighborhood health clinic in the entire city of Anchorage—and again, this is a city that has half the State's population—only one neighborhood health clinic is still accepting new Medicare patients.

So if you are lucky enough to find a physician, it often takes weeks or months for an appointment. So when you are faced with this kind of a delay, you have one of two options. You either go to the emergency room if the conditions are severe enough or you go without care entirely, putting it off until perhaps it becomes even more complicated down the road.

We had testify at the field hearing one gentleman who is from the city of Bethel. Bethel is in the western part of the State. He said he was willing to fly the 500-some-odd miles from Bethel to Anchorage if only he could find a primary care doctor who would accept him. He kind of joked because he said he counted himself lucky because he had a heart condition, and he was at least able to get in to see a specialist once in awhile.

The chairman of the Alaska Commission on Aging, Mr. Frank Appel, called the lack of access to health care for seniors ''the most critical problem facing Alaska's seniors.''

I know Alaska is not alone. The crisis is not just Alaska. It is nationwide. We as a body, as a Congress, should find this situation intolerable.

I haven't been in the Senate for as long as many of my other colleagues, but I have been here long enough to know that we fight a lot about health care. We debate the solvency issues, the funding issues, the insurance, the benefit coverage, universal coverage, health savings accounts, the prescription drug benefit. We debate and argue about a lot of these issues as they relate to health care, and each and every one of these issues is certainly worthy of great debate. But I would submit that not one of those very worthy debates matters in the least to one of the seniors I have mentioned in these letters who can't find a primary care doctor after making 100 phone calls.

So instead of this body debating how health care is delivered, it is time we focus on the fact that it is not delivered in much of America. We have a crisis that, simply put, cannot wait. We have to do two things. We have to help current physicians stay in the practice of medicine, and we must vastly increase our health care work force.

Earlier this year, Senator STEVENS and I introduced the Rural Physician Relief Act, and this is a bill that provides tax incentives for physicians to practice in our most rural and frontier locations in the country. Today, along with my colleagues, Senator SCHUMER, Senator STEVENS, and Senator SANDERS, we are introducing legislation entitled the ''Physician Shortage Elimination Act.'' This legislation will double the funding for the National Health Service Corps, a program that is dedicated to meeting the needs of the underserved. Despite its success over the years, it has been vastly underfunded. We understand that 85 percent of the applicants to this worthy program have to be turned away each year because we don't fund it.

This legislation will also allow rural and underserved physician residency programs to expand by removing barriers that prevent programs from developing rural training programs.

We will also double certain title VII funding to create programs that target disadvantaged youth in rural and underserved areas and nurture them to create a pipeline to careers in health care. We need to get more people interested in the field.

Finally, we must bolster the cornerstone of rural health care, which is the community health center, through additional grants and by allowing them to expand their residency programs.

I would suggest that the prognosis for the quality of health care in America is poor. Fifteen million Americans in underserved areas across the Nation already do without care. Soon, with even greater physician shortages, it could mean that potentially another 84 million patients will be left without a physician's care.

The time for Congress to act is now. In fact, it is past time. I look forward to working with my colleagues on this issue that again is not just Alaska-specific. I think the facts on the ground up North perhaps make the arguments more accentuated, but I think it points to a situation in this Nation that we must deal with now before the crisis is felt throughout the country.

I appreciate the attention of the Chair.

By Ms. MIKULSKI (for herself, Mr. GRASSLEY, Mr. BOND, Mrs. CLINTON, and Ms. COLLINS):

S. 897. A bill to amend the Internal Revenue Code of 1986 to provide more help to Alzheimer's disease caregivers; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I am pleased to join in cosponsoring the Alzheimer's Family Assistance Act of 2007 introduced by my colleague, Senator MIKULSKI.

As much as we all would like to think that we will remain healthy and strong throughout our lifetimes, many of us will need long-term care. The cost of that care, whether provided in a nursing home, assisted living facility, or in one's own home with the assistance of health aides, can quickly add up. That is why we should do everything we can to make people aware of long-term care insurance and to ensure that policies are affordable.

We need to encourage people to include long-term care insurance in their planning, especially when people are younger and premiums would be lower. The Deficit Reduction Act of 2005, DRA, made good progress in that regard by expanding State long-term care partnership programs. In addition, the DRA established an information clearinghouse to help individuals learn about long-term care insurance options in their states.

We also need to encourage older individuals to purchase long-term care insurance. By establishing a deduction for long-term care insurance premiums, this legislation will help accomplish that goal. In order to qualify for the deduction, the policy must include several important consumer protections recommended by the National Association of Insurance Commissioners, NAIC. The DRA incorporated the same protections plus some additional NAIC consumer protections into the State long-term care partnership policies. As this bill moves forward, I look forward to working with Senator MIKULSKI to ensure consistency in the application of these consumer protections to long-term care policies. Specifically, I hope we can expand the consumer protections in this bill so they are in line with those included in the DRA.

Finally, this legislation recognizes that individuals and their caregivers may need assistance in paying for medical supplies, nursing care, and other long-term care expenses. The tax credit called for in the bill, which increases from $1,000 to $3,000 in 2011 and beyond, will help defray these costs.

Mr. President, I have long supported the policies included in this legislation and commend my colleague for her work on this important issue.

By Mr. DODD (for himself, Ms. MIKULSKI, Mrs. MURRAY, Mr. SANDERS, Mr. DURBIN, Mr. LIEBERMAN, Ms. CANTWELL, Mr. AKAKA, and Mr. LEVIN):

S. 899. A bill to amend section 401(b)(2) of the Higher Education Act of 1965 regarding the Federal Pell Grant maximum amount; to the Committee on Health, Education, Labor, and Pensions.

Mr. DODD. Mr. President, I rise today, joined by my colleagues Senators MIKULSKI, MURRAY, SANDERS, DURBIN, LIEBERMAN, CANTWELL, AKAKA, and LEVIN, to introduce legislation to amend the Higher Education Act to improve access to college for low- and moderate-income students by raising the authorized maximum Pell grant to $11,600 within 5 years. This bill has the strong support of the American Association of Universities, American Jesuit Colleges and Universities, the American Association of Community Colleges, the National Association of Independent Colleges and Universities, the American Council on Education, and The Higher Education Consortium for Special Education.

Pell grants were first established in the early 1970s by our former colleague, Senator Claiborne Pell. Pell grants are the largest source of Federal grant aid for college students and make it possible for millions of low- and moderate-income students to attend college. The benefits of Pell grant aid cannot be overstated. Pell grants are beneficial

to individual students as well as our society as a whole. Often, our Nation's great innovators and creative minds sharpen their skills on college campuses. By increasing the Pell grant, we make a college education more affordable, and thus, make it more likely that qualified and hard working low- and moderate-income students will attend. It would be a significant loss to this great Nation if a generation of individuals were not able to earn a college degree simply because they could not afford to pay for it.

In 1975, the maximum appropriated Pell grant covered 80 percent of the average student's tuition, fees, room, and board at 4-year public universities. In 2005–2006, the average Pell grant covered 33 percent of the total charges at 4-year public universities. That's not just a drop in aid, it's a free-fall. For low- and moderate-income families, the cost of college has also increased as a percentage of income. In 1999 it took 43 percent of a low-income family's income to pay for a college education. In 1972, it only took 27 percent. The cornerstone of American democracy is providing all citizens with access and opportunities so that through hard work they can achieve the ''American dream.'' We must keep that dream alive by providing students the financial opportunity to attend college.

In order to meet the cost of attending college, many low- and moderate-income students are forced to take out an exorbitant amount in student loans. Upon graduation these students are often faced with an unmanageable debt load. Surveys tell us that students with a significant amount of debt are postponing marriage and having children. Others are choosing their jobs based on where they think they can afford to work. Clearly, we do not want student loan debt to solely drive our young people's goals and aspirations.

Over the past several years, the administration has not raised the maximum Pell grant. On top of leaving millions of children behind by underfunding K–12 education, they are also leaving students behind who have done well in school and want the chance to go on to college. If we are serious about leaving no student behind—if we are serious about having a society where equal opportunity for all is more than just rhetoric—then we must increase the Pell grant.

It has been said that investing in a student's future is investing in our Nation's future. We can start investing in our Nation's future by supporting this bill to increase the maximum appropriated Pell grant to $11,600. This bill won't bring the Pell grant's purchasing power back to where it was in 1975, but it is a critical first step. I hope that my colleagues will join me in taking this important step toward ensuring all that have the ability to excel in college are given that opportunity.

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

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

S. 899

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

SECTION 1. FEDERAL PELL GRANT MAXIMUM AMOUNT.

Section 401(b)(2) of the Higher Education Act of 1965 (20 U.S.C. 1070a(b)(2)) is amended—

(1) by redesignating subparagraph (B) as subparagraph (C);

(2) by striking subparagraph (A) and inserting the following:

''(A) Except as provided in subparagraph (B), the amount of the Federal Pell Grant for a student eligible under this part shall be—

''(i) $7,600 for academic year 2007–2008;

''(ii) $8,600 for academic year 2008–2009;

''(iii) $9,600 for academic year 2009–2010;

''(iv) $10,600 for academic year 2010–2011; and

''(v) $11,600 for academic year 2011–2012,

less an amount equal to the amount determined to be the expected family contribution with respect to that student for that year.''; and

(3) by inserting after subparagraph (A) (as amended by paragraph (2)) the following:

''(B) If the Secretary determines that the increase from one academic year to the next in the amount of the maximum Federal Pell Grant authorized under subparagraph (A) does not increase students' purchasing power (relative to the cost of attendance at an institution of higher education) by not less than 5 percentage points, then the amount of the maximum Federal Pell Grant authorized under subparagraph (A) for the academic year for which the determination is made shall be increased by an amount sufficient to achieve such a 5 percentage point increase.''.

By Mr. HATCH (for himself and Mr. BENNETT):

S. 900. A bill to authorize the Boy Scouts of America to exchange certain land in the State of Utah acquired under the Recreation and Public Purposes Act; to the Committee on Energy and Natural Resources.

Mr. .HATCH. Mr. President, I rise today to introduce the Boy Scouts of America Land Transfer Act of 2007. This important legislation will allow the exchange of two small parcels of land between the Utah Parks Council of the Boy Scouts of America and Brian Head Ski Resort.

In 1983, the Bureau of Land Management granted the Boy Scouts of America roughly 1,300 acres in Parowan, Utah. The land patent was granted with the stipulation that it be used exclusively for purposes of a Boy Scout camp. The Scout camp, known as Camp Thunder Ridge, is situated in the mountains adjacent to Brian Head Ski Resort and near Cedar Breaks National Monument.

When the land was given to the Scout Camp, a local rancher owned a parcel of land adjacent to the camp and another parcel in the middle of the camp. Upon his retirement, the rancher turned over his parcels, totaling 120 acres, to Brian Head Ski Resort. Thus, the ski resort now owns land in the middle of a Boy Scout Camp.

The Boy Scouts and the Resort agree that the land previously owned by the rancher would best be used as part of Camp Thunder Ridge, while certain parcels of the Scout Camp would be of more use to the Ski Resort.

The Boy Scouts of America Land Transfer Act would allow the Boy Scouts to exchange 120 acres of their land on the south end of the camp with Brian Head for 120 acres on the eastern side of the camp, including the 40 acres located in the middle of the camp. Because of the stipulations of the original BLM patent given to the Scout Camp, legislation is required to authorize this exchange.

While Camp Thunder Ridge is located in a steep, rough, mountainous area, much of the land the Boy Scouts seek is flat, making it particularly important for the camp. Obtaining the land would make it possible for the Scouts to make the camp shooting area and archery range safer and would allow them to improve and expand their camping facilities. It would also allow for the installation of much-needed septic tanks.

I am a strong supporter of the Boy Scouts of America. Scout camps, such as Camp Thunder Ridge, give young men the opportunity to learn vital skills, fulfill merit badge requirements, and otherwise improve themselves. This small land exchange will allow Camp Thunder Ridge to do a better job in helping these young men learn and grow.

For its part, Brian Head Ski Resort is seeking to expand their operations and have received preliminary approval from local officials. The local Planning Commission, however, has required them to build an emergency exit for their property. The only place to build such a road is through land owned by the Boy Scouts. The exchange will allow Brian Head to construct the access road and comply with county fire safety regulations.

The Boy Scouts have been working for more than 20 years to secure the lands in question, and Brian Head needs to build on lands currently owned by the Scouts. Therefore, it would be in the best interest of both parties to authorize this land exchange. In fact, the exchange is desperately needed by both parties, and I urge my colleagues to support this important legislation.

By Mr. KENNEDY (for himself, Mr. HATCH, Mr. DODD, Mr. ROBERTS, Mr. HARKIN, Mr. BOND, Ms. MIKULSKI, Ms. SNOWE, Mr. BINGAMAN, Mr. DOMENICI, Mr. REED, Ms. MURKOWSKI, Mrs. CLINTON, Mr. BENNETT, Mr. OBAMA, Mr. GRASSLEY, Mr. BROWN, and Mr. BURR):

S. 901. A bill to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, tot he Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, it's an honor to join Senator HATCH and my

HELP Committee colleagues today in introducing this bill to reauthorize the community health centers program. The Health Centers Renewal Act extends the program through 2012, it authorizes the funds needed to stabilize existing centers and enable them to increase their capacity and funds for new centers in underserved areas that have no existing center.

The community health centers program has been a success story by any measure over the past 40 years. It began as a two-site demonstration project for ''neighborhood health centers'' in 1965, with funds for Columbia Point in Massachusetts and Mound Bayou in Mississippi. The health center model was the brainchild of two young physicians and civil rights activists, Dr. H. Jack Geiger and Dr. Count Gibson. Their model was intended to address both health care and the roots of poverty, by giving communities a voice in their health care through a patient-majority community board, by creating jobs and investments in local communities, and by focusing on primary care and reducing health disparities among income groups.

Today, more than 1,000 health centers provide good health care to 16 million patients each year. They provide safety nets in their communities for the most vulnerable Americans, and bring care to 1 of every 4 Americans living in poverty. Nearly 70 percent of health center patients have incomes below the poverty line, and two-thirds are members of racial and ethnic minorities. Health centers give those who are so often disenfranchised in our society a voice in their own health care and in the care available in their community. Health centers are also an incentive for economic growth, providing 50,000 jobs across the country for residents in their communities.

As the number of uninsured and underinsured persons grows each year, the need for health center services increases. More than 40 percent of health center patients have no health insurance and their number is increasing. Another 36 percent of patients have coverage through Medicaid or CHIP, and cuts in these programs affect health centers as well. As the number of patients who rely on health centers continues to grow, we must provide the funds needed to open new centers in areas that are underserved and to provide additional funds to enable existing centers to meet the growing demand for care.

The funding authorized in this bill will provide stability and expanded services in existing centers, and enable new centers to open in areas that have no centers today. The legislation will keep health centers on track to serve 20 million patients by 2010 and more than 23 million patients by 2012. It also provides the funds needed to expand existing health centers to reach more uninsured and underinsured patients, open new centers in underserved areas with no current centers, expand coverage of mental health, dental, and pharmacy services to all centers, invest in information technology, and take other steps to improve health outcomes. Our goal in the bill is to make sure that health centers can provide high-quality care to their patients for years to come, and I look forward to its enactment into law.

I ask unanimous request that the text of the bill be printed in the RECORD.

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

S. 901

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Centers Renewal Act of 2007''.

SEC. 2. FINDINGS.

Congress finds as follows:

(1) Community, migrant, public housing, and homeless health centers are vital to thousands of communities across the United States.

(2) There are more than 1,000 such health centers serving more than 16,000,000 people at more than 5,000 health delivery sites, located in all 50 States of the United States, the District of Columbia, and Puerto Rico, Guam, the Virgin Islands, and other territories of the United States.

(3) Health centers provide cost-effective, quality health care to poor and medically underserved people in the States, the District of Columbia, and the territories, including the working poor, the uninsured, and many high-risk and vulnerable populations, and have done so for over 40 years.

(4) Health centers provide care to 1 of every 8 uninsured Americans, 1 of every 4 Americans in poverty, and 1 of every 9 rural Americans.

(5) Health centers provide primary and preventive care services to more than 700,000 homeless persons and more than 725,000 farm workers in the United States.

(6) Health centers are community-oriented and patient-focused and tailor their services to fit the special needs and priorities of local communities, working together with schools, businesses, churches, community organizations, foundations, and State and local governments.

(7) Health centers are built through community initiative.

(8) Health centers encourage citizen participation and provide jobs for 50,000 community residents.

(9) Congress established the program as a unique public-private partnership, and has continued to provide direct funding to community organizations for the development and operation of health centers systems that address pressing local health needs and meet national performance standards.

(10) Federal grants assist participating communities in finding partners and recruiting doctors and other health professionals.

(11) Federal grants constitute, on average, 24 percent of the annual budget of such health centers, with the remainder provided by State and local governments, Medicare, Medicaid, private contributions, private insurance, and patient fees.

(12) Health centers make health care responsive and cost-effective through aggressive outreach, patient education, translation, and other enabling support services.

(13) Health centers help reduce health disparities, meet escalating health care needs, and provide a vital safety net in the health care delivery system of the United States.

(14) Health centers increase the use of preventive health services, including immunizations, pap smears, mammograms, and HBa1c tests for diabetes screenings.

(15) Expert studies have demonstrated the impact that these community-owned and patient-controlled primary care delivery systems have achieved both in the reduction of traditional access barriers and the elimination of health disparities among their patients.

SEC. 3. ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR HEALTH CENTERS PROGRAM OF PUBLIC HEALTH SERVICE ACT.

Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by amending paragraph (1) to read as follows:

''(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

''(A) $2,188,745,000 for fiscal year 2008;

''(B) $2,451,394,400 for fiscal year 2009;

''(C) $2,757,818,700 for fiscal year 2010;

''(D) $3,116,335,131 for fiscal year 2011; and

''(E) $3,537,040,374 for fiscal year 2012.''.

Mr. HATCH. Mr. President, today I am introducing the Health Centers Renewal Act with my colleagues, Senators KENNEDY, ROBERTS, DODD, BOND, HARKIN, SNOWE, MIKULSKI, DOMENICI, BINGAMAN, MURKOWSKI, REED, BENNETT, CLINTON, GRASSLEY, OBAMA, BURR and BROWN.

The Health Centers program, created over 40 years ago, has an outstanding record of providing quality health care services to many Americans who do not have adequate health insurance. This ranges from children to parents and grandparents, in virtually every comer of the United States. In fact, Health Centers are a necessary component of our nation's health care safety net—they supply health services to over 15 million people in our country.

Health Centers include community health centers, which are local, not-for-profit 501(c)(3) corporations that give community-oriented health care and are governed by Boards of Directors that are made up of at least 51 percent health centers patients, to ensure that the patients and their communities are well represented.

From my work in Utah, I know how important Health Centers are. They have made a tremendous difference for Utah's citizens with insufficient health coverage—Utah community health centers serve close to 85,000 patients. Whenever I come home to Utah, I always hear wonderful things about the work of Community Health Centers.

Since 2001, Congress has consistently increased funding for Community Health Centers to meet President Bush's goal of having 1,200 new or expanded centers. The new dollars have provided services to four million new patients and have added facilities in over 750 communities across the country. By reauthorizing this program, Health Centers will give low-cost health care to many more deserving individuals.

S. 901 I will reauthorize the Health Centers program for 5 more years; it includes funding levels of: $2,188,745,000

in fiscal year 2008; $2,451,394,400 in fiscal year 2009; $2,757,818,700 in fiscal year 2010; $3,116,335,131 in fiscal year 2011; and $3,537,040,374 in fiscal year 2012. These numbers are based on the National Association of Community Health Centers; NACHC, growth plan—NACHC's goal is for Community Health Centers to serve 20 million patients a year by 2010 and 30 million patients a year by 2015.

I believe that Community Health Centers are worth every dime that our government invests in them.

Utah Health Centers have made a tremendous difference in the lives of many Utahns—66 percent of patients come from Utah's urban areas and 27 percent are from the rural parts of the state. Ninety-six percent of Utah Health Center patients' incomes are below 200 percent of the Federal Poverty Level. Utah Health Centers have literally changed these patients' lives, serving as a link to the health care safety net system for the medically underserved and uninsured. In rural areas, Health Centers are often the only health care provider.

Community Health Centers have made a huge impact on people's lives. I am pleased and proud to support them by introducing this legislation today.

I urge my colleagues to cosponsor this important bill, which not only provides people with essential health care services, but also ensures that the Health Centers will continue to have the funding necessary to provide these services.

By Mr. HARKIN (for himself, Mr. LEAHY, Mr. KERRY, Mr. LAUTENBERG, Mr. ROCKEFELLER, Ms. LANDRIEU, and Ms. CANTWELL):

S. 902. A bill to provide support and assistance for families of members of the National Guard and Reserve who are undergoing deployment, and for other purposes; to the Committee on Armed Services.

Mr. HARKIN. Mr President, Americans are divided over the Iraq war, but we are 100 percent united in our determination to support the troops in the field and their families back home.

But just as we have seen shortcomings in the treatment of wounded warriors at Walter Reed, it is clear to me that we are falling short in supporting the families of Guard and Reserve personnel who serve in Iraq and Afghanistan. These families are especially vulnerable because of their isolation, their distance from military bases, and their lack of access to the services that active-duty military families can draw upon.

This is a new era for our National Guard and for the Reserves. They are shouldering a huge share of the combat burden in Iraq and Afghanistan, plus a stepped-up role in homeland security. More than four times as many Guard members have been killed in Iraq as during the entire Vietnam war.

With many Guard and Reserve members on their third or even fourth deployment, and with some deployments being stretched out to 16 months, the stresses on their families are acute. Their children are at greater risk for depression, behavioral disorders, or academic problems. And long family separations often result in financial difficulties and troubled marriages.

To address this quiet crisis, today I am introducing legislation titled the Coming Together for Guard and Reserve Families Act. This bill does several things.

First, it expands and strengthens the existing family assistance program. We need to ensure that there is adequate professional staff to work with Guard and Reserve families and meet their special needs at every point of the deployment cycle—as they prepare for deployment, during the long absence, and during reunification and readjustment.

I am especially concerned that there are few resources for the families of Guard and Reserve members who are wounded or experience mental illness. My bill expands the VA's Disabled Transition Assistance program to ensure that family members have access to family counseling and mental health services during this critical time.

Children of deployed service members often react to parental separation with acting-out behaviors, anxiety, or depression. My bill calls for outreach to professionals who serve children—including school administrators and teachers—to alert them to the special needs of kids in military families, especially those with a parent deployed in a war zone.

Forty-one percent of Guard members and Reservists report symptoms of mental illness—including post-traumatic stress disorder—within 6 months of returning home from deployment. Currently, mental health information is distributed to service members when they return from deployment—and often that's it. But symptoms of PTSD may not appear for months after return. My bill will ensure that families receive mental health information 6 months post-deployment.

Finally, my bill creates a family-to-family mentoring program to enable military spouses to serve as peer counselors to other spouses and family members. It can be extremely valuable for a military spouse to consult with someone who has gone through a similar experience.

The role of our Guard and Reserve members in defending our national security abroad has significantly increased. In turn, we have an expanded obligation to care for their spouses and children, who are facing tremendous stresses, often alone and with no one to turn to.

The aim of my bill is to address the unmet needs of Guard and Reserve families before this becomes the kind of full-fledged crisis we witnessed at Walter Reed. I urge my colleagues to support this urgent and important legislation.

By Mr. DURBIN (for himself, Mr. BENNETT, Mrs. CLINTON, Mr. KERRY, and Mr. HARKIN):

S. 903. A bill to award a Congressional Gold Medal to Dr. Muhammad Yunus, in recognition of his contributions to the fight against global poverty; to the Committee on Banking, Housing, and Urban Affairs.

Mr. DURBIN. Mr. President, I rise today to honor Dr. Muhammad Yunus for his contributions to the fight against global poverty.

Today, joined by my colleague Senator BENNETT of Utah as well as Senators CLINTON, KERRY and HARKIN, I introduced the Muhammad Yunus Congressional Gold Medal Act.

This bipartisan bill would award Dr. Yunus a Congressional Gold Medal in recognition of his efforts to fight poverty and promote economic and social opportunity.

Along with the Grameen Bank, which he founded, Dr. Yunus was awarded the Nobel Peace Prize in 2006 for developing the concept of microcredit. Through the Grameen system, Dr. Yunus created an economically sound model of extending very small loans, at competitive interest rates, to the very poor. Through this system, he has been transforming lives, one loan at a time.

He began in 1976 with a loan of just $27, out of his own pocket, to 42 village craftspeople in Bangladesh. Over the past 30 years, his model has been emulated around the world.

I met Dr. Yunus on my first trip to Bangladesh, and there I saw firsthand the economic miracle that microcredit can help create.

Nearly half the world's population lives on less than $2 a day. We can not hope to achieve lasting global peace and stability until we find a means by which the world's poorest can begin to lift themselves out of poverty.

The microcredit movement that Dr. Yunus pioneered has made enormous strides towards that goal. Over 125 million households have already been transformed by microcredit loans, and more are joining them every day.

Dr. Yunus' work has had a particularly strong impact on improving the economic prospects of women. Women disproportionately shoulder the burden of poverty. They also make up over 95 percent of microcredit borrowers.

I have long believed that if you want to predict the economic prospects of a country, ask how it treats its women. If a country sends its daughters to school, if its wives and mothers have economic and political rights and opportunities, then it is likely to prosper. But if it treats its women as second-class citizens, its chances for development diminish dramatically. Microcredit opens doors for women and in so doing it creates new opportunities for their sons and daughters alike.

Muhammad Yunus's work has also affected the lives of millions of Americans. Although Dr. Yunus launched his movement in 1976 in Bangladesh—a long time ago and a long way away—it

has come home to us here in America and is still relevant today.

There are now an estimated 21 million microentrepreneurs in the U.S., accounting for approximately 16 percent of private employment in the country. Over $318 million worth of microloans have been made to American entrepreneurs in the past 15 years.

Culminating with his Nobel Peace Prize, Dr. Yunus has been recognized around the world as a leading figure in the effort to fight poverty and promote economic and social opportunity.

It is time that we properly recognize him here in Congress with our most distinguished honor.

Dr. Yunus would join a long and illustrious line of Congressional Gold Medal recipients that stretches back to 1776, when the award was created. Although most of the recipients have been American, many have not: Prime Minister Tony Blair, Pope John Paul II, and His Holiness, the Fourteenth Dalai Lama, are just a few. We hope that Dr. Yunus will join them.

I want to thank Senator BENNETT and my other colleagues for joining me today in honoring Dr. Yunus. Dr. Muhammad Yunus is a great man who deserves our admiration and our thanks.

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

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

S. 903

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

SECTION 1. FINDINGS.

Congress finds that—

(1) Dr. Muhammad Yunus is recognized in the United States and throughout the world as a leading figure in the fight against poverty and the effort to promote economic and social change;

(2) Muhammad Yunus is the recognized developer of the concept of microcredit, and Grameen Bank, which he founded, has created a model of lending that has been emulated across the globe;

(3) Muhammad Yunus launched this global movement to create economic and social development from below, beginning in 1976, with a loan of $27 from his own pocket to 42 crafts persons in a small village in Bangladesh;

(4) Muhammad Yunus has demonstrated the life-changing potential of extending very small loans (at competitive interest rates) to the very poor and the economic feasibility of microcredit and other microfinance and microenterprise practices and services;

(5) Dr. Yunus's work has had a particularly strong impact on improving the economic prospects of women, and on their families, as over 95 percent of microcredit borrowers are women;

(6) Dr. Yunus has pioneered a movement with the potential to assist a significant number of the more than 1,000,000,000 people, mostly women and children, who live on less than $1 a day, and the nearly 3,000,000,000 people who live on less than $2 a day, and which has already reached 125,000,000 households, by one estimate;

(7) there are now an estimated 21,000,000 microentrepreneurs in the United States (accounting for approximately 16 percent of private (nonfarm) employment in the United States), and the Small Business Administration has made over $318,000,000 in microloans to entrepreneurs since 1992;

(8) Dr. Yunus, along with the Grameen Bank, was awarded the Nobel Peace Prize in 2006 for his efforts to promote economic and social opportunity and out of recognition that lasting peace cannot be achieved unless large population groups find the means, such as microcredit, to break out of poverty; and

(9) the microcredit ideas developed and put into practice by Muhammad Yunus, along with other bold initiatives, can make a historical breakthrough in the fight against poverty.

SEC. 2. CONGRESSIONAL GOLD MEDAL.

(a) PRESENTATION AUTHORIZED.—The Speaker of the House of Representatives and the President pro tempore of the Senate shall make appropriate arrangements for the presentation, on behalf of Congress, of a gold medal of appropriate design, to Dr. Muhammad Yunus, in recognition of his many enduring contributions to the fight against global poverty.

(b) DESIGN AND STRIKING.—For purposes of the presentation referred to in subsection (a), the Secretary of the Treasury (referred to in this Act as the ''Secretary'') shall strike a gold medal with suitable emblems, devices, and inscriptions, to be determined by the Secretary.

SEC. 3. DUPLICATE MEDALS.

The Secretary may strike and sell duplicates in bronze of the gold medal struck pursuant to section 3, under such regulations as the Secretary may prescribe, at a price sufficient to cover the cost thereof, including labor, materials, dies, use of machinery, and overhead expenses, and the cost of the gold medal.

SEC. 4. STATUS OF MEDALS.

(a) NATIONAL MEDALS.—The medals struck pursuant to this Act are national medals for purposes of chapter 51 of title 31, United States Code.

(b) NUMISMATIC ITEMS.—For purposes of sections 5134 and 5136 of title 31, United States Code, all medals struck under this Act shall be considered to be numismatic items.

SEC. 5. AUTHORITY TO USE FUND AMOUNTS; PROCEEDS OF SALE.

(a) AUTHORITY TO USE FUND AMOUNTS.—There are authorized to be charged against the United States Mint Public Enterprise Fund, such amounts as may be necessary to pay for the costs of the medals struck pursuant to this Act.

(b) PROCEEDS OF SALE.—Amounts received from the sale of duplicate bronze medals authorized under section 4 shall be deposited into the United States Mint Public Enterprise Fund.

Mr. KERRY. Mr. President, I rise today to recognize Dr. Muhammad Yunus. For those who don't already know, Dr. Yunus is a modest man of great ideas, now revered around the world, as the father of microcredit and the founder of the Grameen Bank. His concept of microcredit has helped thousands of people work their way out of poverty. For his work to beat global poverty, I am very proud to join my colleagues, Senators DURBIN and BENNETT, in introducing a bill to honor Dr. Yunus with a Congressional Gold Medal.

When I look at the success of Dr. Yunus's idea and the microenterprise programs it has inspired over the past 30 years, one thing that amazes me the most is that it all began with a loan of 27 U.S. dollars. The beauty of microcredit is that such a small amount of money can have such tremendous and lasting effects to foster entrepreneurship among those who would not qualify for typical bank loans. By offering loans at competitive interest rates, or no interest, Dr. Yunus's Grameen Bank has been able to give individuals suffering from poverty the power to determine their own futures.

Last year, Dr. Yunus and his Grameen Bank were honored with a Nobel Peace Prize for his economic imagination. Dr. Yunus's innovation and entrepreneurship are certainly commendable and worthy of such an honor, as well as the distinction of a Congressional Gold Medal. In accepting his Nobel Peace Prize, Dr. Yunus challenged the world to think of an entrepreneur as not only being motivated by profit, but also by ''doing good to people and the world.''

The effectiveness of microcredit programs is evident by the success stories they have inspired all around the world. As chairman of the Small Business and Entrepreneurship Committee, I have seen first hand the power of microcredit in this country, through the SBA's—Small Business Administration's—microloan programs. In my home State of Massachusetts, Thondup and Dolma Tsering, two Tibetan refugees in the United States, were able to start their own restaurant in 2005, with assistance from the Massachusetts Small Business Development Center and financing from the Western Massachusetts Enterprise Fund. Through financing and support, otherwise not available to them from the banking community, they are now the successful owners of Lhasa Cafe in Northampton. As small business owners, the Tserings are socially responsible and support local farmers and their community.

From Dr. Yunus's first microloans to 42 entrepreneurs in Bangladesh in 1976, the concept of microcredit has come a long way. Here in the United States, where SBA has had a similar program since 1992, more than $328 million in microloans have been made to deserving entrepreneurs.

I have long been a supporter of funding microloan programs, which offer current and potential small business owners the opportunity to achieve financial independence, financial security, and dignity through work. Sometimes they use it to work their way out of poverty, but sometimes they use it to patch together income when they need more money, lose a job, want to buy a house or car, or maybe pay for college or send a child to college. These entrepreneurs create jobs, provide services and products to our communities, and generate tax revenue to benefit the economy. Funding microloan programs not only makes economic sense; it makes social sense as well.

In spite of growing support for microloan programs, and in spite of the

return on investment to our economy, microenterprise does not get the support in this country that it does in other countries. In 2005, the administration provided approximately $211 million for the development of foreign microenterprise programs through the Agency for International Development, USAID. In fiscal year 2006, we are told that the administration provided more than $54 million for microloans in Iraq:

The efforts of the U.S. government in its assistance to Iraq have been broad based. . . For example, over $54 million in micro-loans have been disbursed, resulting in 26,700 loans in twelve cities, and the program is set to expand to even more areas. Also, a Loan Guarantee Corporation is currently being established to encourage private banks to make loans to small businesses.—Ambassador Zalmay Khalilzad, U.S. Ambassador to Iraq, May 9, 2006.

And for fiscal year 2007, we are told that the administration is requesting supplemental funding for Iraq that includes at least $160 million for microloans.

We will help local leaders improve their capacity to govern and deliver public services. Our economic efforts will be more targeted on specific local needs with proven records of success, like micro-credit programs. And we will engage with leading private sector enterprises and other local businesses, including the more promising state-owned firms, to break the obstacles to growth.—Secretary of State Condoleezza Rice, Foreign Relations Committee hearing on the administration's plan for Iraq, January 11, 2007.

At the same time, the President has proposed for fiscal years 2005, 2006, 2007, and 2008 eliminating all funding for the SBA's microloan programs.

Today I not only honor and recognize the genius of Dr. Yunus, but also call attention to President Bush's lack of support for U.S. microloans and call on the administration to reverse its policy. If we can support microloans in Baghdad, we should support microloans in Boston, and every other city that's home to a would-be entrepreneur.

I am honored to add my name in support of Dr. Muhammad Yunus, and I am gratified to see the support he has received among my colleagues. But I also implore my colleagues to pay tribute to American entrepreneurs and to fund the SBA's microloan program. We must honor Dr. Yunus's ingenuity with more than words; we must honor him with our actions.

By Ms. SNOWE (for herself, Mr. PRYOR, and Mr. CRAIG):

S. 904. A bill to provide additional relief for small business owners ordered to active duty as members of reserve components of the Armed Forces, and for other purposes; to the Committee on Small Business and Entrepreneurship.

Ms. SNOWE. Mr. President, I rise today to introduce the Veterans Small Business Opportunity Act of 2007. Senators PRYOR, CRAIG, and I are introducing this legislation to assist veterans and small businesses that employ Guard and reservists. Our bill improves the Small Business Administration's, SBA's, Military Reservist Economic Injury Disaster Loan, MREIDL, program. Additionally, this bill increases procurement opportunities, capital access, and other types of business development assistance for veterans and service-disabled veterans.

We all know today's small business men and women play a vital role in the economic stability and prosperity of our Nation. Quite often, these same entrepreneurs are the veterans who have protected our Nation in years past, or who serve in the Armed Forces today. When our Nation's patriotic men and women are called to duty, they often leave behind thriving small businesses, and as a result, many of these businesses experience production slowdowns and lost sales, or incur additional expenses to compensate for an employee's absence.

In recent years, the Department of Defense has placed a greater reliance on our country's Guard and Reserve Forces. In fact, since September 2001, nearly 600,000 Guard and Reserve members have been called up in support of current operations, comprising nearly one-third of deployed service members in Iraq and Afghanistan. Furthermore, Guard and Reserve members were charged with assisting recovery efforts in the gulf coast region in the aftermath of Hurricanes Katrina and Rita.

In my 4 years as chair of the Senate Committee on Small Business and Entrepreneurship, and now as ranking member, I have fought to support our patriotic small businesses affected by the Guard and Reserve call-ups. My home State of Maine has one of the highest Guard and Reserve deployment levels in the country—over 50 percent have been deployed to Iraq and Afghanistan. In response to this I commissioned a Congressional Budget Office, CBO, study which found that 35 percent of Guard and reservists work for small busineses or are self-employed. In addition, the small businesses that employ them may be ''paying'' a disproportionate and unfair share of the burden of increased Guard and Reserve member call-ups. The burden is further magnified when it is the small business owner or a key employee who is deployed.

Our legislation will raise the maximum MREIDL amount from $1,500,000 to $2,000,000. A maximum military reservist loan amount of $2,000,000 is the same level as many of the SBA's other loan programs, including: 7(a) loans, international trade loans, and 504 Certified Development Corporation loans that serve a public policy goal.

Currently, some of the SBA's contracting and business development programs have defined time limits for participation. If the firm's time for participation expires prematurely, then competitive opportunities, investments, and jobs become lost. Today, small business owners who get called-up to active duty in the National Guard or Reserve are effectively penalized because their active duty time is counted against the time limitation participation in the SBA's programs. The Veterans Small Business Opportunity Act amends the Small Business Act by allowing small businesses owned by veterans and service-disabled veterans to extend their SBA program participation time limitations by the duration of their owners' active duty service after September 11, 2001.

Additionally, this bill will allow the SBA Administrator, either directly or through banks, to offer loans up to $25,000 without requiring collateral from a loan applicant. Currently, the SBA offers military reservist loans up to $5,000 without collateral. This provision would increase that level to eligible small businesses.

The bill will also require the Administrator to give military reservist loan applications priority for processing and ensure that Guard and Reserve members are adequately assisted with their loan application by incorporating the support and expertise of SBA entrepreneurial development partners, such as Small Business Development Centers and Veterans Business Outreach Centers.

This legislation increases the authorization of appropriations for the SBA's Office of Veteran Business Development to $2 million for fiscal year 2008, $2.1 million for fiscal year 2009 and $2.2 million for fiscal year 2010. Increased funding for SBA's Office of Veterans Business Development help them better assist our Nation's veterans and provide the business services they need.

This legislation will also strengthen the access of veterans and service-disabled veterans to Federal contracts and subcontracts. Under the Small Business Act and the President's Executive Order 13360, Providing Opportunities for Service-Disabled Veteran Businesses To Increase Their Federal Contracting and Subcontracting, Federal agencies must award at least 3 percent of prime contracts and subcontracts to small businesses owned by service-disabled veterans. The order states that, to achieve these goals, Federal agencies ''shall more effectively'' use the authorities in the Small Business Act to reserve and award contracts to service-disabled veterans. During the Senate Small Business and Entrepreneurship Committee hearing held in January, it became very clear that Federal agencies have been short-changing service-disabled veteran-owned small businesses to the tune of over $7.5 billion a year in government contracts during fiscal year 2003 through fiscal year 2005. To remedy this unacceptable situation, our legislation puts the force of a congressional statute behind the requirements of the President's Executive order.

In addition, our legislation ensures that veterans and service-disabled veterans do not face confusing and duplicative red tape before they can be eligible to access the Federal procurement market. Currently, the Department of

Veterans Affairs and the SBA both operate registration databases for small businesses owned by veterans and service-disabled veterans. A veteran must often register in both databases to be properly considered for bidding. Surely, in this information age, we can have a better process. Registration data can easily be made to migrate from one database to the other. Our legislation requires that a single registration point for both of these databases be established within a year. Such one-stop registration must be reliable and compliant with statutory provisions concerning veteran and service-disabled veteran status certifications for small businesses.

To increase the capacity of service-disabled veteran-owned firms, my legislation permits the SBA, in cooperation with the Department of Veterans Affairs, to develop a business development assistance program, including mentor-protégé assistance, to be administered by the SBA. Our legislation contains a strict fairness requirement that any such program must be developed in such a way as to ensure success of other small business contracting programs. Within a year, the SBA is required to submit a report to Congress on its proposals for this program. In 2004, I succeeded in amending the Department of Defense Mentor-Protégé Program statute by expanding it to service-disabled veterans. Since then, over $204 million in contracts and subcontracts have been awarded to service-disabled veteran-owned small businesses as a result of the $17 million in mentor-Protégé assistance. This represents a stunning $12 return for every $1 in assistance investment. I believe the success of this initiative should be replicated. The SBA is already administering a Mentor-Protégé Program as part of the 8(a) business development program for small disadvantaged businesses, and both the SBA and the DOD programs would provide useful examples for helping our disabled veterans succeed.

Finally, our legislation creates an interagency task force among Federal agencies charged with improving procurement opportunities for service-disabled veterans. The scope of this task force will, in addition to procurement, include franchising, capital access, and other types of business development assistance. In examining the implementation of Executive Order 13360 and other veterans business development initiatives, our committee found that the responsible agencies were not talking to each other on a regular basis, and that no overall ''game plan'' was in place to coordinate various Federal efforts.

I would like to thank Senators PRYOR and CRAIG for working with me on this critical issue and I urge my colleagues to support this bill.

Mr. CRAIG. Mr. President, I rise to comment on a bill that is being introduced by Senator SNOWE today, the Veterans Small Business Opportunity Act of 2007. I am proud to join with Senator SNOWE and Senator PRYOR as an original cosponsor of this important bill.

This legislation will benefit patriot ''citizen-soldiers'' who are called from their employment at America's small businesses to serve our country in uniform. In States across the Nation, small businesses are being affected by the mobilization of our Guard and Reserve personnel. In my home State, the Idaho National Guard's 116th Brigade Combat Team returned in 2005 from an 18-month deployment to Iraq. I visited members of the 116th while they were in Iraq and discovered that a good number had left jobs at small businesses across Idaho. I also held a hearing in Idaho during the 109th Congress to examine the reemployment rights of returning Guard and Reserve members.

At that hearing, it was emphasized that, although legal rights to reemployment are critical, they do little for those who have no employer, or no small business, to return to. To me, it was clear that we should do more to help small businesses in coping with the financial hardships of frequent and lengthy mobilizations of its employees or owners during the war on terrorism. I believe we can provide some of that needed assistance with this legislation, which includes key provisions from The Patriot Loan Act of 2006, a bill that Senator SNOWE and I introduced last year.

This bill would enhance the U.S. Small Business Administration's Military Reservist Economic Injury Disaster Loan, or MREIDL, Program. That program provides loan assistance to small businesses to help them meet ordinary and necessary operating expenses after essential employees are called to active duty in their roles as citizen-soldiers.

This bill would raise the maximum military reservist loan amount from $1.5 million to $2 million. It would also allow the Small Business Administration, by direct loan or through banks, to offer unsecured loans of up to $25,000, an increase from the current $5,000 limit. In addition, this bill would ensure proactive outreach to Guard and Reserve members about the MREIDL Program and other small business programs by requiring SBA and the Department of Defense to develop a joint Web site and printed materials with information about those programs.

For the brave men and women who serve our Nation in the Guard and Reserve, we must do what we can to ensure that their sacrifices do not place them in financial harm's way when they return home. I urge my colleagues to support these measures, and I thank Senator SNOWE for her leadership in introducing this bill.

By Mr. INHOFE:

S. 905. A bill to amend the Internal Revenue Code of 1986 to eliminate the taxable income limit on percentage depletion for oil and natural gas produced from marginal properties; to the Committee on Finance.

Mr. INHOFE. Mr. President, the independent producers of oil and gas are the backbone of our domestic supply of energy. They have played and continue to play a critical role in meeting our domestic needs, especially as the big oil companies' focus mainly offshore. In fact, independents develop 90 percent of our Nation's wells. According to the Department of Energy, independent producers supply 68 percent of American oil production and 82 percent of overall American natural gas.

Therefore, I rise today to introduce legislation that eliminates the taxable income limit on percentage depletion for oil and natural gas produced from marginal wells; wells producing 15 barrels of day and less than 90 thousand cubic feet of natural gas.

Under current law, the percentage depletion method is limited to only independent producers and royalty owners. It is a form of cost recovery for capital initially invested toward production of oil and gas wells. Generally, the percentage depletion rate is 15 percent of the taxpayer's gross income from an oil and gas producing property and is limited to a daily average of 1,000 barrels of oil or 6,000 thousand cubic feet of natural gas. However, under the net income limitation, percentage depletion is limited to 100 percent of the net income from an individual property. In the case of marginal wells, where total deductions often do exceed this net-income, this limitation discourages producers from investing in the continued production from marginal wells.

As a result Congress has suspended the net-income limitation for 1998 through 2005; and again for 2006 and 2007, with the passage of the Tax Relief and Health Care Act of 2006, H.R. 6111.

My bill would simply clarify the policy by doing away with the taxable net income limitation altogether.

In my own State of Oklahoma, it is the small independents, basically mom-and-pop operations, producing the majority of oil and natural gas, with 85 percent of Oklahoma's oil coming from marginal wells.

Because marginal wells supply such a significant amount of our oil and gas, it is vital we keep them in operation. According to the Energy Department, between 1994 and 2003, we lost 110 million barrels of crude oil due to plugged marginal wells. Thus, when we lose marginal wells, we become more dependent upon foreign sources of energy, at a time when virtually all agree that U.S. policies should encourage reliance upon domestic sources. Furthermore, we lose domestic jobs to foreign nations.

My bill would allow independents the necessary capital to continue to produce from these existing marginal wells—which is critical to the Nation's overall energy security. I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 905

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

SECTION 1. ELIMINATION OF TAXABLE INCOME LIMIT ON PERCENTAGE DEPLETION FOR OIL AND NATURAL GAS PRODUCED FROM MARGINAL PROPERTIES.

(a) IN GENERAL.—Subparagraph (H) of section 613A(c)(6) of the Internal Revenue Code of 1986 (relating to oil and natural gas produced from marginal properties) is amended to read as follows:

''(H) NONAPPLICATION OF TAXABLE INCOME LIMIT WITH RESPECT TO MARGINAL PRODUCTION.—The second sentence of subsection (a) of section 613 shall not apply to so much of the allowance for depletion as is determined under subparagraph (A).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2006.

By Mr. OBAMA (for himself and Ms. MURKOWSKI):

S. 906. A bill to prohibit the sale, distribution, transfer, and export of elemental mercury, and for other purposes; to the Committee on Environment and Public Works.

Mr. OBAMA. Mr. President, I am pleased to be joined today by my esteemed colleague from Alaska, Ms. MURKOWSKI, in introducing the Mercury Market Minimization Act of 2007.

As most of us in this Chamber know, elemental mercury is a poisonous neurotoxin that can cause serious disability or death if ingested. Unfortunately, many people in the United States, and many millions more worldwide, do indeed ingest mercury—unintentionally, however, as a result of industrial emissions or practices, or poor waste management and storage techniques. When mercury enters into the environment, it often shows up in plants and animals, and that means a major source of mercury ingestion for humans comes as a result of eating certain types of fish. That, in turn, causes serious developmental problems in half a million children in our country, and similar health problems in adults, especially women at childbearing age.

Last year, an investigative report published in the *Chicago Tribune* outlined the extent of mercury contamination in fish. After concluding that the fish sampling efforts conducted by the Federal Government were limited and outdated, the *Tribune* conducted its own sampling, and the results showed surprisingly high levels of mercury concentrations in freshwater and saltwater fish purchased by consumers in the Chicago region—higher levels than had been documented by the Federal Government. Mercury was found in both freshwater and saltwater species—tuna, swordfish, orange roughy, and walleye, to name a few examples. The *Tribune* also reported on how existing programs at the Food and Drug Administration and the Environmental Protection Agency have failed to adequately test and evaluate mercury levels in fish.

For those of us who like fish, it causes us to pause when we first learn of the range of species with high mercury levels. For pregnant women and other at-risk groups, however, this doesn't just cause pause, it creates serious concerns about health consequences. Meanwhile, experts tell us that fish is an excellent source of critical nutrients and other compounds indispensable for good health. More of us should eat more fish.

So the real long-term solution is not to eat less fish, or to criticize those who commercially provide us with fish as food. It's not about issuing advisories, or printing labels on tuna cans, or posting placards at the supermarket, or creating inspection bureaucracies, or collecting statistics. If we're serious about eliminating mercury from fish, we need to reduce mercury in the environment.

Half of mercury settles where it is emitted, and the other half gets transported around the globe where we lose track of it, and it winds up in oceans, lakes, and rivers nowhere near mercury sources. From there, up it goes, through the food chain. If mercury is both local, and global, then the solution is not up to one state, or one nation, but up to all states and nations. The bill we introduce today was crafted based on that premise.

The Mercury Market Minimization Act, or M3 Act, establishes a ban on U.S. exports of mercury by the year 2010. Such a ban, when coupled with goal of the European Union to ban mercury exports by 2011, and the insufficient capacity in the world's mercury mines to respond, will result in a tightening of the global supply of commercially available elemental mercury in sufficient quantities that developing nations that still use mercury will be compelled to switch to the affordable alternatives that are already widespread in industrialized nations.

The M3 Act also requires those Federal agencies that now hold mercury in stockpiles to keep that mercury. Right now, the Department of Energy, and the Department of Defense, possess tons of mercury left over from various operations over the years. While it is the policy of these agencies to keep this mercury—not to sell it, not to transfer it, not to release it from their possession—it is not the law. The M3 act codifies these policies. In December of 2006, it was widely understood that the Department of Energy was considering the sale of its mercury stockpiles. After various inquiries into the matter, the Department of Energy ultimately announced that it would not sell its stockpiles. That underscores why a prohibition of stockpile sales must be enacted into law by the M3 act if we are to be assured that mercury remains safely stored, away from the environment, and not sold overseas to places where tracking and emissions and waste disposal laws may be inadequate.

Finally, the M3 Act calls for the creation of a committee to explore and make recommendations on the issues associated with the development of a permanent repository of mercury collected as a result of an export prohibition. Mercury is not like spent nuclear fuel, or other substances that may create community concerns, in that when mercury is stored in stainless steel containers in refrigeration, it remains benign. Every community must be provided the opportunity to evaluate for themselves if and when mercury is stored nearby in secure and stable storage. I do believe, however, that when mercury is safely and permanently stored, it means less microscopic mercury on one's dinner plate, less mercury in our kids' tuna fish sandwiches, and less mercury in the air we breathe.

Last month, a United States delegation, led by the State Department, participated in an international meeting in Kenya, sponsored by the United Nations Environmental Programme, where world representative discussed how to reduce mercury pollution. Two years ago, the U.S. Government could have taken a bolder stance, and did not. This time, with the decision of the E.U. to ban mercury exports, the United States had an opportunity to partner with its allies to eliminate a major part of worldwide elemental mercury contamination. Again, the State Department did not.

It is not often that policy options, such as this, might be considered ''low-hanging fruit''—in that a small act of international leadership by the United States government could have far reaching benefits for the health of our kids, as well as millions of low-income hardworking artisanal gold miners whom we will never meet. But the United States, so far, has not acted. This bill, the M3 bill, is designed to change that course and the mark the beginning of the end of a global market of an outdated and obsolete poison. I hope my colleagues will support this bill, and I ask unanimous consent that a copy of this legislation be printed in the RECORD.

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

S. 906

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Mercury Market Minimization Act of 2007''.

SEC. 2. FINDINGS.

Congress finds that—

(1) mercury and mercury compounds are highly toxic to humans, ecosystems, and wildlife;

(2) as many as 10 percent of women in the United States of childbearing age have mercury in the blood at a level that could put a baby at risk;

(3) as many as 630,000 children born annually in the United States are at risk of neurological problems related to mercury;

(4) the most significant source of mercury exposure to people in the United States is ingestion of mercury-contaminated fish;

(5) the Environmental Protection Agency reports that, as of 2004—

(A) 44 States have fish advisories covering over 13,000,000 lake acres and over 750,000 river miles;

(B) in 21 States the freshwater advisories are statewide; and

(C) in 12 States the coastal advisories are statewide;

(6) the long-term solution to mercury pollution is to minimize global mercury use and releases to eventually achieve reduced contamination levels in the environment, rather than reducing fish consumption since uncontaminated fish represents a critical and healthy source of nutrition worldwide;

(7) mercury pollution is a transboundary pollutant, depositing locally, regionally, and globally, and affecting water bodies near industrial sources (including the Great Lakes) and remote areas (including the Arctic Circle);

(8) the free trade of mercury and mercury compounds on the world market, at relatively low prices and in ready supply, encourages the continued use of mercury outside of the United States, often involving highly dispersive activities such as artisinal gold mining;

(9) the intentional use of mercury is declining in the United States as a consequence of process changes to manufactured products (including batteries, paints, switches, and measuring devices), but those uses remain substantial in the developing world where releases from the products are extremely likely due to the limited pollution control and waste management infrastructures in those countries;

(10) the member countries of the European Union collectively are the largest source of mercury exports globally;

(11) the European Union is in the process of enacting legislation that will prohibit mercury exports by not later than 2011;

(12) the United States is a net exporter of mercury and, according to the United States Geologic Survey, exported 506 metric tons of mercury more than the United States imported during the period of 2000 through 2004; and

(13) banning exports of mercury from the United States will have a notable affect on the market availability of mercury and switching to affordable mercury alternatives in the developing world.

SEC. 3. PROHIBITION ON SALE, DISTRIBUTION, OR TRANSFER OF MERCURY BY DEPARTMENT OF DEFENSE OR DEPARTMENT OF ENERGY.

Section 6 of the Toxic Substances Control Act (15 U.S.C. 2605) is amended by adding at the end the following:

''(f) MERCURY.—

''(1) PROHIBITION ON SALE, DISTRIBUTION, OR TRANSFER OF MERCURY BY FEDERAL AGENCIES.—Except as provided in paragraph (2), effective beginning on the date of enactment of this subsection, no Federal agency shall convey, sell, or distribute to any other Federal agency, any State or local government agency, or any private individual or entity any elemental mercury under the control or jurisdiction of the Federal agency.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a transfer between Federal agencies of elemental mercury for the sole purpose of facilitating storage of mercury to carry out this Act.''.

SEC. 4. PROHIBITION ON EXPORT OF MERCURY.

Section 12 of the Toxic Substances Control Act (15 U.S.C. 2611) is amended—

(1) in subsection (a) by striking ''subsection (b)'' and inserting ''subsections (b) and (c)''; and

(2) by adding at the end the following:

''(c) PROHIBITION ON EXPORT OF MERCURY.—

''(1) ELEMENTAL MERCURY.—Effective January 1, 2010, the export of elemental mercury from the United States is prohibited.

''(2) REPORT TO CONGRESS ON MERCURY COMPOUNDS.—

''(A) REPORT.—

''(i) IN GENERAL.—Not later than 1 year after the date of enactment of the Mercury Market Minimization Act of 2007, the Administrator shall publish and submit to Congress a report on mercuric chloride, mercurous chloride or calomel, mercuric oxide, and other mercury compounds, if any, that may currently be used in significant quantities in products or processes.

''(ii) INCLUSIONS.—The report shall include an analysis of—

''(I) the sources and amounts of each mercury compound produced annually in, or imported into, the United States;

''(II)(aa) the purposes for which each of the compounds are used domestically;

''(bb) the quantity of the compounds currently consumed annually for each purpose; and

''(cc) the estimated quantity of the compounds to be consumed for each purpose during calendar year 2010 and thereafter;

''(III) the sources and quantities of each mercury compound exported from the United States during each of the preceding 3 calendar years;

''(IV) the potential for the compounds to be processed into elemental mercury after export from the United States; and

''(V) other information that Congress should consider in determining whether to extend the export prohibition to include 1 or more of those mercury compounds.

''(B) PROCEDURE.—

''(i) IN GENERAL.—Except as provided in clause (ii), for the purpose of preparing the report under this paragraph, the Administrator may use the information gathering authorities of this title, including sections 10 and 11.

''(ii) EXCEPTION.—Subsection (b)(2) of section 11 shall not apply to activities under this subparagraph.

''(3) EXCESS MERCURY STORAGE ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—There is established an advisory committee, to be known as the 'Excess Mercury Storage Advisory Committee' (referred to in this paragraph as the 'Committee').

''(B) MEMBERSHIP.—

''(i) IN GENERAL.—The Committee shall be composed of 9 members, of whom—

''(I) 2 members shall be jointly appointed by the Speaker of the House of Representatives and the Majority Leader of the Senate—

''(aa) 1 of whom shall be designated to serve as Chairperson of the Committee; and

''(bb) 1 of whom shall be designated to serve as Vice-Chairperson of the Committee;

''(II) 1 member shall be the Administrator;

''(III) 1 member shall be the Secretary of Defense;

''(IV) 1 member shall be a representative of State environmental agencies;

''(V) 1 member shall be a representative of State attorneys general;

''(VI) 1 member shall be a representative of the chlorine industry;

''(VII) 1 member shall be a representative of the mercury waste treatment industry; and

''(VIII) 1 member shall be a representative of a nonprofit environmental organization.

''(ii) APPOINTMENTS.—Not later than 45 days after the date of enactment of this subsection, the Administrator, in consultation with the appropriate congressional committees, shall appoint the members of the Committee described in subclauses (IV) through (VIII) of clause (i).

''(C) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Committee have been appointed, the Committee shall hold the initial meeting of the Committee.

''(D) MEETINGS.—The Committee shall meet at the call of the Chairperson.

''(E) QUORUM.—A majority of the members of the Committee shall constitute a quorum.

''(F) REPORT.—Not later than 1 year after the date of enactment of this subsection, the Committee shall submit to Congress a report describing the findings and recommendations of the Committee, if any, relating to—

''(i) the environmental, health, and safety requirements necessary to prevent—

''(I) the release of elemental mercury into the environment; and

''(II) worker exposure from the storage of elemental mercury;

''(ii) the estimated annual cost of storing elemental mercury on a per-pound or per-ton basis;

''(iii) for the 40-year period beginning on the date of submission of the report, the optimal size, number, and other characteristics of Federal facilities required to store elemental mercury under current and anticipated jurisdictions of each Federal agency;

''(iv) the estimated quantity of—

''(I) elemental mercury that will result from the decommissioning of mercury cell chlor-alkali facilities in the United States; and

''(II) any other supplies that may require storage to carry out this Act;

''(v) for the 40-year period beginning on the date of submission of the report, the estimated quantity of elemental mercury generated from the recycling of unwanted products and other wastes that will require storage to comply with the export prohibitions under this Act;

''(vi) any legal, technical, economic, or other barrier that may prevent the private sector from storing elemental mercury produced by the private sector during the 40-year period beginning on the date of submission of the report, including a description of measures to address the barriers;

''(vii) the advantages and disadvantages of consolidating the storage of mercury produced by public and private sources under the management of the public or private sector;

''(viii) the optimal plan of the Committee for storing excess mercury produced by public and private sources; and

''(ix) additional research, if any, required to determine a long-term disposal option for the storage of excess mercury.

''(G) COMPENSATION OF MEMBERS.—

''(i) IN GENERAL.—

''(I) NON-FEDERAL EMPLOYEES.—A member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Committee.

''(II) FEDERAL EMPLOYEES.—A member of the Committee who is an officer or employee of the Federal Government shall serve without compensation in addition to the compensation received for the services of the member as an officer or employee of the Federal Government.

''(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

''(H) STAFF AND FUNDING.—The Administrator shall provide to the Committee such funding and additional personnel as are necessary to enable the Committee to perform the duties of the Committee.

''(I) TERMINATION.—The Committee shall terminate 180 days after the date on which the Committee submits the report of the Committee under subparagraph (F).

''(4) INAPPLICABILITY OF UNREASONABLE RISK REQUIREMENT.—Subsection (a) shall not apply to this subsection.''.

By Mrs. CLINTON:

S. 907. A bill to establish an Advisory Committee on Gestational Diabetes, to provide grants to better understand and reduce gestational diabetes, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. CLINTON. Mr. President, I am pleased to introduce the Gestational Diabetes Act of 2007 with my colleague Senator COLLINS, to bring attention to an important health issue facing women and children.

I don't need to tell anyone that we have an obesity epidemic in the United States. Many of us realize that as parents, it is our responsibility to pass on good nutritional habits to our children. But many women may not realize that watching what you eat, exercising regularly, and having control of your blood sugar levels are serious health considerations during pregnancy. In fact, these factors are serious enough that they can affect both the health of the mother and the life of the child into adulthood.

More women than ever are entering their pregnancies overweight but without an understanding of how their own weight and nutritional habits can trigger gestational diabetes—a type of diabetes that only occurs during pregnancy. Women who are overweight before pregnancy are not only at greater risk of having gestational diabetes but are also more likely to have a c-section and are at an increased risk for other serious pregnancy complications.

In New York, gestational diabetes is on the rise. In New York City alone, gestational diabetes has risen by nearly 50 percent in about 10 years. This means that gestational diabetes affects 1 in 25 women, about 400 women per month. But across the Nation, between 4 and 8 percent of pregnant women in the United States are affected by gestational diabetes. Infants of women who have gestational diabetes are at increased risk for obesity and developing type 2 diabetes as adolescents or adults.

As women, we need to pay attention to our health. We are always worrying about the health of our children, our husbands, and our parents, but we often forget to take care of ourselves.

Today, I am introducing the Gestational Diabetes Act, also known as the GEDI Act. This legislation will increase our understanding of gestational diabetes by determining the factors that contribute to this condition and help mothers who had gestational diabetes reduce their risk of developing type 2 diabetes post-pregnancy.

The GEDI Act will provide funding for projects to assist health care providers, as well as for communities to find ways to reach out to women so that they understand how their own good health during pregnancy can decrease serious health risks for their children.

The GEDI Act would expand research to determine and develop interventions to lower the incidence of gestational diabetes. We need to alert women to the risk before this condition becomes an epidemic and, as we have seen so many times before, education is critical.

We should be doing everything we can to address the impact of obesity during pregnancy and to reduce the prevalence of gestational diabetes in pregnant women. The GEDI Act is an important step in assuring that women understand this critical issue and that we fully understand how to equip pregnant women to make the best choices for their health.

The GEDI Act is supported by the American Diabetes Association, American College of Obstetricians and Gynecologists, National Research Center for Women & Families, International Community Health Services, American Association of Diabetes Educators, and the American Association of Colleges of Pharmacy.

By Mr. BINGAMAN (for himself, Mr. AKAKA, Mr. KERRY, and Mrs. CLINTON):

S. 909. A bill to amend title XIX of the Social Security Act to permit States, at their option, to require certain individuals to present satisfactory documentary evidence of proof of citizenship or nationality for purposes of eligibility for Medicaid, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, the legislation I am introducing today is designed to make several very important changes to current law to ensure that U.S. citizens receive the Medicaid to which they are entitled.

Since July 1, 2006, most U.S. citizens and nationals applying for or renewing their Medicaid coverage face a new Federal requirement to provide documentation of their citizenship status. Recent reports indicate that tens-of-thousands of U.S. citizens, and in particular children, inappropriately are being denied Medicaid benefits simply because they don't have access to newly required documentation. The articles below and report by the Center on Budget and Policy Priorities highlight this very serious problem. Hospitals, physicians, and pharmacies may not be willing to treat these individuals until they have a source of payment, but they cannot qualify for Medicaid until they produce a birth certificate and ID.

This new Federal requirement was added to Medicaid by the Deficit Reduction Act of 2005, DRA, enacted February 8, 2006. The Tax Relief and Health Care Act of 2006, TRHCA, signed into law December 20, 2006, included some amendments to the DRA citizenship documentation requirement, primarily to exempt certain groups. Prior to enactment of the DRA, States were permitted to use their discretion in requiring such citizenship documentation.

Under Section 6036 of the DRA, citizens applying for or renewing their Medicaid coverage must provide ''satisfactory documentary evidence of citizenship or nationality.'' The DRA specifies documents that are acceptable for this purpose and authorizes the HHS Secretary to designate additional acceptable documents. No Federal matching funds are available for services provided to individuals who declare they are citizens or nationals unless the State obtains satisfactory evidence of their citizenship or determines that they are subject to a statutory exemption.

It is important to note that citizenship documentation requirements do not affect Medicaid rules relating to immigrants—they apply to individuals claiming to be citizens. Most new legal immigrants are excluded from Medicaid during their first 5 years in the U.S. and undocumented immigrants remain eligible for Medicaid emergency services only.

The legislation I am introducing would make several very important changes to current law to ensure that U.S. citizens receive the Medicaid to which they are entitled.

First, the legislation would restore citizenship verification to a State option. Specifically, States would be permitted to determine when and to what extent citizenship verification is required of U.S. Citizens. States would also be permitted to utilize the standards most appropriate to the their population as long as such standards were no more stringent than those currently used by the Social Security Administration and includes native American tribal documents when appropriate.

Second, the legislation would ensure that individuals are afforded a reasonable time period to provide citizenship documentation utilizing the same reasonable time period standard that is available to legal immigrants to provide satisfactory evidence of their immigration status.

Third the legislation protects children who are U.S. citizens by virtue of being born in the United States from being denied coverage after birth because of citizenship verification requirements.

Fourth, the legislation also clarifies ambiguities in federal law to ensure that these citizen children, regardless of the immigration status of their parents, are treated like all other low-income children born in the United States and are deemed eligible to receive Medicaid services for one year.

Finally, the legislation also ensures that the thousands of citizen children and adults, who were erroneously denied Medicaid coverage, may receive

retroactive Medicaid eligibility for coverage they were inappropriately denied because of citizenship verification requirements.

I urge my colleagues in the Senate to support this critical legislation, which protects low-income U.S. citizens from being inappropriately denied Medicaid coverage because of lack of documentation.

I ask unanimous consent that the text of the bill and supporting documentation be printed in the RECORD.

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

S. 909

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

SECTION 1. STATE OPTION TO REQUIRE CERTAIN INDIVIDUALS TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID.

(a) IN GENERAL.—Section 1902(a)(46) of the Social Security Act (42 U.S.C. 1396a(a)(46)) is amended—

(1) by inserting ''(A)'' after ''(46)'';

(2) by adding ''and'' after the semicolon; and

(3) by adding at the end the following new subparagraph:

''(B) at the option of the State and subject to section 1903(x), require that, with respect to an individual (other than an individual described in section 1903(x)(1)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the criteria used by the Social Security Administration to determine citizenship, and which shall accept as such evidence a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood, and, with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph));''.

(b) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary of Health and Human Services may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.

(c) CONFORMING AMENDMENTS.—Section 1903 of such Act (42 U.S.C. 1396b) is amended—

(1) in subsection (i)—

(A) in paragraph (20), by adding ''or'' after the semicolon;

(B) in paragraph (21), by striking ''; or'' and inserting a period; and

(C) by striking paragraph (22); and

(2) in subsection (x) (as amended by section 405(c)(1)(A) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432))—

(A) by striking paragraphs (1) and (3);

(B) by redesignating paragraph (2) as paragraph (1);

(C) in paragraph (1), as so redesignated, by striking ''paragraph (1)'' and inserting ''section 1902(a)(46)(B)''; and

(D) by adding at the end the following new paragraph:

''(2) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.''.

SEC. 2. CLARIFICATION OF RULES FOR CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.

Section 1903(x) of such Act (42 U.S.C. 1396b(x)), as amended by section 1(c)(2), is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''or'' at the end;

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

''(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or''; and

(2) by adding at the end the following new paragraph:

''(3) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.''.

SEC. 3. EFFECTIVE DATE.

(a) RETROACTIVE APPLICATION.—The amendments made by this Act shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 4).

(b) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the date of enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by sections 1 and 2, had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

[From the Associated Press, Nov. 29, 2006]

KS: SEBELIUS: NEW MEDICAID RULES COULD COST STATE MILLIONS

(By John Hanna)

The state could face millions of dollars in additional costs because of federal rules requiring Medicaid recipients to verify their citizenship, Gov. Kathleen Sebelius said Wednesday.

Sebelius said she's worried the state will have to pick up the full cost of caring for some poor, frail and elderly Kansans who are living in nursing homes, instead of sharing the cost with the federal government. Also, she said, she will propose adding state employees to verify the citizenship status of Medicaid recipients and applicants.

The governor told reporters she hopes Congress reviews the issue and other attempts to prevent illegal immigrants from obtaining social services or using driver's licenses as identification.

''There was no input from the states on how realistic these were or what the cost was,'' Sebelius said during a brief news conference following an unrelated meeting.

Under Medicaid requirements that took effect July 1, recipients must provide either a passport or two other documents, such as a birth certificate and a driver's license, to verify citizenship.

While the measure is targeted at illegal immigrants, some advocates for the needy have worried that citizens will either lose or be denied services because they have trouble finding the necessary documents.

State officials say the number of Kansans covered by Medicaid dropped almost 7 percent since July 1, down to 253,000 from 271,000. They believe much of the decline can be attributed to the new requirements.

Typically, every $1 the state spends on Medicaid is matched by about $1.50 from the federal government. If someone loses their coverage, then the state faces paying the entire bill for their services, Sebelius said.

''You're at 100 percent state dollars or push them out the door,'' she said.

Also, Sebelius said, the state needs to ''ramp up'' its staffing to handle the additional verification work. The governor is working on the budget proposal she'll submit to the 2007 Legislature, which convenes Jan. 8.

''We're certainly going to put some of them in place,'' she said. ''We're trying to make a careful analysis of how many we need.''

She said that if the state refuses to comply with the law, it could face the loss of all federal health care dollars.

''We don't have a lot of latitude to say we're not going to do this,'' she said. ''There are literally hundreds of millions of dollars at stake.''

Meanwhile, Sebelius expressed concern about a federal law on driver's licenses passed last year.

Starting in 2008, federal agencies won't treat a state's licenses as valid ID unless a state requires license applicants to document that they're living in the United States legally. Lack of ID could prevent someone from entering a federal building or boarding a plane.

Sebelius said the law will require local driver's licenses offices to certify that someone has the proper documentation and to store the information.

''Exactly how that's going to happen, we're not quite sure,'' Sebelius said. ''We don't basically have any of the equipment that's required to do that in any of the rural areas.''

[From the Associated Press, Nov. 29, 2006]

KS: THOUSANDS IN KANSAS OFF MEDICAID FOLLOWING CITIZENSHIP RULES

Thousands of low-income Kansans have lost or been denied state health care coverage because of new rules requiring them to prove they are American citizens, state officials say.

Since the federally mandated rules took effect July 1, the number of Medicaid recipients in Kansas has decreased by about 18,000, to 253,000. While officials can't determine exactly how much of the 7 percent drop can be attributed to the new rules, they believe much of it can.

''The impact to the consumer has been severe,'' said John Anzivino, a vice president for MAXIMUS, a Reston, Va., company that helps administer the joint federal-state Medicaid program in Kansas. ''From our perspective, this has possibly been the most dramatic change and challenge to the Medicaid program since its inception.''

The new rules were included in last year's federal deficit reduction law and were designed to prevent illegal immigrants from enrolling in the state programs providing health coverage.

But consumer advocates said many vulnerable people who legitimately were eligible for assistance would lose coverage because they couldn't produce the necessary documentation.

''We expect that many of these that have lost coverage will regain coverage once they have gathered and provided the necessary documentation,'' Marcia Nielsen, executive director of the Kansas Health Policy Authority, told the Lawrence Journal-World. ''They will, however, experience a gap in coverage that could prove to be significant for some.''

Medicaid applicants can prove their citizenship by providing a passport. Or they can provide other documents that verify both their citizenship, such as a birth certificate, and their identities, such as a driver's license.

Anzivino said most people seeking benefits don't have a passport and are left scrambling to find birth certificates and other documents.

The number of calls each month to a Kansas Medicaid clearinghouse has more than doubled to 49,000 from 23,000, official said.

Meanwhile, Rep. Dennis Moore, a Democrat whose district is centered on the state's portion of the Kansas City area, said federal officials were aware of states' problems with the new rules and probably would work on it when the new Congress takes office in January.

[From the Baltimore Sun, Jan. 22, 2007]

MD: MEDICAID CALLED HARDER FOR POOR; HEALTH ADVOCATES FEAR DOCUMENT RULES CAUSE MANY TO LOSE COVERAGE

(By Kelly Brewington)

Public health advocates fear that a new federal regulation requiring Medicaid applicants to supply proof of identity and citizenship has resulted in thousands of poor Marylanders losing their health insurance.

The requirement, part of the federal Deficit Reduction Act that went into effect in Maryland in September, was designed to prevent illegal immigrants from fraudulently receiving Medicaid, the nation's premier health insurance program for the poor.

But advocates and health officers in some Maryland counties insist the rule has burdened citizens who need health care the most and is likely responsible for thousands of Marylanders being kicked off the Medicaid rolls.

''It's a completely unnecessary law and Congress made a big mistake in passing it,'' said Laurie Norris, an attorney with the Public Justice Center. ''The people who are on Medicaid in Maryland are supposed to be on Medicaid.''

The announcement of the regulations last June sparked an uproar among advocates and state health officials, who were given a July 1 deadline to enforce the mandate or risk losing federal funding. The officials complained they were not given enough time to train staff and inform Maryland's approximately 650,000 affected Medicaid recipients that they must furnish such identification as birth certificates, driver's licenses and passports.

Nationwide, advocates feared huge enrollment declines, saying many of Medicaid's neediest recipients don't possess the necessary documents and would have to struggle to come up with the money to obtain them. Maryland, for instance, does not automatically issue birth certificates, which may be ordered for $12.

Last summer, the federal government exempted from the requirement elderly and disabled Medicaid recipients who receive Supplemental Security Income from Social Security, and last month it extended the exemption to foster children. Still, states such as Virginia, Iowa, Wisconsin and New Hampshire noted plunging Medicaid enrollment figures and backlogs related to the regulation, according to a report released earlier this month by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. In Virginia, 12,000 children have been dropped from Medicaid rolls in the requirement's first four months of implementation, the report stated.

In Maryland, Medicaid enrollment numbers are down overall, but state health officials say they are unsure whether the drop is due to the new rule, a point that has frustrated county health officers eager for evidence of the regulation's impact that they could use to push for change.

From August through December 2006, the state Department of Health and Mental Hygiene recorded about 6,000 fewer Medicaid enrollees statewide compared with the same period in 2005. Maryland officials say the enrollment computer system is not configured to determine the exact cause of the decline.

''It is imperative that the state disclose data to demonstrate the impact of this law,'' said Dr. Joshua Sharfstein, Baltimore health commissioner. ''There are warning signs that a major erosion in health coverage could be happening as a result of this new law. This is really concerning. . . .''

Charles Lehman, who oversees eligibility issues in the state's Medicaid office, said the agency has concentrated its limited resources on ''keeping people on Medicaid rather than tracking the people going off.''

''It may not sound like we are doing everything we can, but really, we are, with the resources we have,'' he said. ''It's not just the clients, not just the caseworkers, everyone has been impacted by this.''

Officials said while applicants are typically allowed a 30-day grace period, caseworkers will not discontinue the insurance if applicants are ''making a good-faith effort'' to obtain the documents.

''I think we have done a good job applying the law appropriately but not in a way that arbitrarily cuts people off,'' said Lehman. ''We have made our best effort to keep people on.''

The department has spent $1 million for a toll-free number to help applicants, 866–676–5880.

The state health department has also partnered with other state databases to verify the citizenship and identity of beneficiaries, without requiring recipients to hand over documents. In July, the agency searched birth certificate records for about 600,000 Medicaid enrollees at the cost of $12 per search, said Lehman.

But the effort has not gone as smoothly as hoped, said Norris, with the Public Justice Center. For instance, the databases are not automatically synched—staff must print out the information and check it by hand.

''The state has been severely hampered in information technology,'' she said.

Norris alerted state lawmakers to the problem at a briefing in Annapolis last week. The problems come during a push by advocates and some lawmakers and business groups to expand Medicaid and help about 780,000 uninsured Marylanders.

Officials with local agencies have increased outreach and said they have allowed people extra time to provide the documents they need.

Nevertheless, in Anne Arundel County, for example, denial rates for the state's Medicaid program for pregnant women and children have jumped from an average of 18 percent from June through December 2005 to 42 percent for the same period in 2006.

''It's really shocking,'' said Frances Phillips, the county's health officer. ''This is so serious because the people we are talking about are either children with no insurance and no way to access health care, or pregnant women.''

Many applicants eventually produce the documents and get back on Medicaid, Phillips noted. But for vulnerable populations, any discontinuation in coverage can be harmful, she said.

A health department program in which nurses make home visits to women with at-risk pregnancies has focused on educating women on the documentation. ''We just feel that this is so critical,'' said Phillips. '' . . . We touch base with the women, find out what is going on with them and make sure they get insurance.''

In Baltimore, outreach workers with Baltimore HealthCare Access Inc., which assists some of the city's estimated 200,000 Medicaid enrollees, are making home visits and contacting state agencies on applicants' behalf.

The agency received $5,000 from the Abell Foundation to help applicants cover the cost of documents.

''We are plowing away that money pretty quickly,'' said Kathleen Westcoat, the organization's president.

The funding helped Brenda Kent, 36, pay for her birth certificate last month. She lost her wallet two months before she was due to apply for Medicaid benefits for herself, her twin sons and a daughter.

''I didn't know how I was supposed to get it,'' said Kent, who does not work. ''If they didn't help me with the cost, it would have taken me longer to do it.''

[From the Associated Press, Sept. 1, 2006]

NC: U.S. CITIZENSHIP PROOF REQUIRED FOR MEDICAID IN N.C.

A requirement that Medicaid recipients in North Carolina prove they hold U.S. citizenship probably won't uncover a large amount of fraud, a state official says.

Starting Sept. 1, new Medicaid applicants and nearly every current beneficiary must provide documentation of their citizenship as part of a new federal law designed to prevent illegal immigrants from receiving the health care coverage.

''I would be very surprised if we had a problem in our state with any large number of people receiving benefits who were not entitled to receive them,'' said Mark Benton, senior deputy director for the state Division of Medical Assistance.

The law was to have taken effect nationwide July 1, but North Carolina delayed its start while it prepared for the changes.

Under the old rules, social services workers were supposed to ask applicants about their citizenship status. They were permitted to accept an applicant's word unless there was reasonable doubt.

Now, the person seeking Medicaid will have to provide a U.S. passport, or an original birth certificate with a driver's license, or other combinations of eligible documents.

Regardless of citizenship, people who need emergency care will continue to receive it through Medicaid, although this type of care is for a limited time period.

Officials say there is no way to know how many illegal immigrants are on Medicaid. Some argue illegal immigrants aren't enrolling in large numbers in a government program like this for fear of being deported.

Illegal immigrants received emergency care of nearly $53 million in 2005, more than double the amount from 2000, according to the division.

The changes nationwide will save Medicaid, the government-run health care program for the poor and disabled, about $735 million by 2015, according to Congressional Budget Office estimates.

CHILDREN DROPPING OFF MEDICAID ROLLS

(AP) For several years, there has been a steady increase in the number of children enrolling in Virginia's health insurance program for the poor. Beginning July 1, state officials say, an unprecedented slide began.

Over the following five months, about 12,000 children dropped off the state's Medicaid rolls.

''An entire year's growth has been wiped out,'' said Cynthia Jones, chief deputy director for the state's Department of Medical Assistance Services.

The drop-off, Jones points out, began about the time a new federal law took effect. The law states that U.S. citizens applying for Medicaid or renewing their participation must present proof of their citizenship and identity. The law emerged out of concern that illegal immigrants were obtaining access to health insurance coverage sponsored by the government.

But some officials say that's not who is losing coverage.

Besides Virginia, some other states are also reporting declines in children enrolled in Medicaid or a decline in applications. They include Iowa, Louisiana, New Hampshire and Wisconsin. Health researchers say they don't know if the states are representative of a nationwide pattern.

The states singled out as experiencing enrollment declines were included in a report issued Tuesday by the Kaiser Family Foundation, which conducts health research, and by the Center on Budget and Policy Priorities, a liberal think tank.

The states experiencing declines are adamant that U.S. citizens and certain legal immigrants are dropping off the Medicaid rolls, not illegal immigrants.

''There is no evidence that the decline is due to undocumented aliens leaving the program,'' said Anita Smith of the Iowa Department of Human Services. ''Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity.''

Medicaid is a health insurance program serving about 55 million people that is financed by the federal government and the states. The declines cited would indicate that just a fraction of the people enrolled in the program have dropped out as a result of the documentation requirements, but they do represent vulnerable populations, such as pregnant women and children.

''We've delayed coverage for those children, and if those children need medical care, there's going to be ramifications for them,'' said Donna Cohen Ross, outreach director for the Center on Budget and Policy Priorities.

But the agency that oversees Medicaid questioned claims that would link enrollment declines to the new documentation requirements.

''We believe we've given the states tools they need to both implement the law and provide sufficient flexibility to assist individuals in establishing their citizenship,'' said Jeff Nelligan, spokesman for the Centers for Medicare and Medicaid Services. ''We continue to monitor state implementation and are not aware of any data that shows there are significant barriers to enrollment.

''If states are experiencing difficulties, they should bring them to our attention as we certainly want to understand why they are not using the flexibilities we have provided.''

After Congress passed the documentation requirements, Medicaid officials released rules that established which documents would suffice in meeting the law.

Primary evidence, namely a U.S. passport or a certificate of U.S. citizenship, is considered the ideal. Secondary evidence or lower-tier evidence must be accompanied by a document showing identity. Such evidence includes birth certificates, insurance records, and as a last resort, written affidavits.

Original documents or copies certified by the issuing agency are required by the regulation. Copies are not acceptable. The federal government excluded millions of seniors and disabled people from the new documentation requirements. In December, Congress also approved an exception for foster children.

NEW MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENT IS TAKING A TOLL: STATES REPORT ENROLLMENT IS DOWN AND ADMINISTRATIVE COSTS ARE UP

(By Donna Cohen Ross)

INTRODUCTION

A new federal law that states were required to implement July 1 is creating a barrier to health-care coverage for U.S. citizens—especially children—who are eligible for health insurance through Medicaid. The new law, a provision of the Deficit Reduction Act of 2005, requires U.S. citizens to present proof of their citizenship and identity when they apply for, or seek to renew, their Medicaid coverage. Prior to enactment of the law, U.S. citizens applying for Medicaid were permitted to attest to their citizenship, under penalty of perjury.

In the six months following implementation of the new requirement, states are beginning to report marked declines in Medicaid enrollment, particularly among low-income children. States also are reporting significant increases in administrative costs as a consequence of the requirement.

This analysis presents the data available so far on this matter. The available evidence strongly suggests that those being adversely affected are primarily U.S. citizens otherwise eligible for Medicaid who are encountering difficulty in promptly securing documents such as birth certificates and who are remaining uninsured for longer periods of time as a result.

The new requirement also appears to be reversing part of the progress that states made over the past decade in streamlining access to Medicaid for individuals who qualify, and especially for children. For example, to improve access to Medicaid and reduce administrative costs, most states implemented mail-in application procedures, and many states reduced burdensome documentation requirements. The new Medicaid citizenship documentation requirement now appears to be pushing states in the opposite direction, by impeding access to Medicaid. Families must furnish more documentation and may be required to visit a Medicaid office in person to apply or renew their coverage, bypassing simpler mail-in and on-line enrollment opportunities, because they must present original documents such as birth certificates that can take time and money to obtain. This is likely to cause the most difficulty for working-poor families that cannot afford to take time off from work to visit the Medicaid office and for low-income families residing in rural areas.

The new citizenship documentation requirement—which the Bush Administration did not request and the Senate initially did not adopt, but which the House of Representatives insisted upon in conference—was presented by its proponents as being necessary to stem a problem of undocumented immigrants securing Medicaid by falsely declaring themselves to be U.S. citizens. The new requirement was adopted despite the lack of evidence that such a problem existed. In response to a report in 2005 by the Inspector General of the Department of Health and Human Services, Mark McClellan, then the Administrator of the Centers for Medicare and Medicaid Services at HHS, noted: ''The [Inspector General's] report does not find particular problems regarding false allegations of citizenship, nor are we aware of any.

IMPACT OF THE CITIZEN DOCUMENTATION REQUIREMENT ON MEDICAID APPLICANTS AND BENEFICIARIES: THE EARLY EVIDENCE

Medicaid enrollment figures for all states for the period since the new requirement was implemented on July 1 are not yet available. By contacting several individual states that do have such data, however, we were able to secure enrollment information from Wisconsin, Kansas, Iowa, Louisiana, Virginia and New Hampshire. The data show the following:

All six states report a significant drop in enrollment since implementation of the requirement began.

Medicaid officials in these states attribute the downward trend primarily or entirely to the citizenship documentation requirement.

Two types of problems are surfacing:

Medicaid is being denied or terminated because some beneficiaries and applicants cannot produce the specified documents despite, from all appearances, being U.S. citizens; and

Medicaid eligibility determinations are being delayed, resulting in large backlogs of applications, either because it is taking time for applicants to obtain the required documents or because eligibility workers are overloaded with the new tasks and paperwork associated with administering the new requirement.

Some states have designed mechanisms specifically to track enrollment changes resulting from the new procedures. Wisconsin, for example, has established computer codes to distinguish when Medicaid eligibility is denied or discontinued due to a lack of citizenship or identity documents. In other states, a comparison of current and past enrollment trends strongly suggests that the new requirement is largely responsible for the enrollment decline. For example, in many states aggressive ''back to school'' outreach activities conducted in August and September usually result in increased child enrollment in September and October. In 2006, however, states such as Virginia and Louisiana reported that child enrollment declined despite vigorous promotional campaigns, indicating that the new requirement undermined the value of the outreach efforts.

The Medicaid enrollment declines identified in this memo do not appear to be driven by broader economic trends or a change in the employment of low-income families. If that were the case, parallel enrollment decline trends would appear in the Food Stamp Program, which is the means-tested program whose enrollment levels are most responsive to such developments. Instead, Food Stamp caseloads have been increasing slightly in recent months. Moreover, each of the states identified in this memo as having sustained a drop in Medicaid enrollment saw its food stamp caseload rise during a similar period.

Both Medicaid and the Food Stamp Program serve similar populations of low-income families and are often administered by the same agencies and caseworkers. A key difference is that the citizenship documentation rules were applied to Medicaid but there were no such changes in the Food Stamp Program. It thus appears that the changes in Medicaid enrollment are a result of changes in Medicaid policies—particularly citizenship documentation—that do not affect eligibility for food stamps.

The following states have documented declines in Medicaid enrollment since the implementation of the Medicaid citizenship documentation requirement:

Wisconsin: In five months—between August and December 2006—a total of 14,034 Medicaid-eligible individuals were either denied Medicaid or lost coverage as a result of the documentation requirement. The loss of Medicaid coverage occurred despite Wisconsin's efforts to minimize the impact of the requirement by obtaining birth records electronically from the state's Vital Records agency. Obtaining proof of identify, rather than proof of citizenship, was the major problem for people in Wisconsin who were otherwise eligible during this period: 69 percent of those who were denied Medicaid or who lost Medicaid coverage due to the new requirement did not have a required identity document, as compared to 17 percent who did not provide the required citizenship documents and 14 percent who were missing both a citizenship and identity document. This indicates that most of those who were denied were, in fact, U.S. citizens.

Kansas: The Kansas Health Policy Authority (KHPA) reports that between 18,000 and 20,000 applicants and previous beneficiaries, mostly children and parents, have been left without health insurance since the citizenship documentation requirement was implemented. About 16,000 of these individuals are ''waiting to enroll'' or ''waiting to be re-enrolled;'' the state says these eligibility determinations are being delayed because of a large backlog of applications related to the difficulties confronting individuals and eligibility workers alike who are attempting to comply with the new rule. Documents on the KHPA website state that the ''majority of families with pending applications will qualify for coverage under the new requirements when we are able to complete processing.'' In the meantime, these children and parents are barred from getting the health coverage for which they qualify and are, in most cases, uninsured.

Iowa: Iowa has identified an unprecedented decline in Medicaid enrollment that state officials attribute to the Medicaid citizenship documentation requirement. Prior to July 1, 2006, overall Medicaid enrollment had steadily increased for the past several years. While sporadic declines occurred in rural counties, no county in the state's larger population centers experienced a decline in the months leading up to the implementation of the new requirement. However, between July and September 2006, Medicaid enrollment sustained the largest decrease in the past five years; this also was the first time in five years that the state has experienced an enrollment decline for three consecutive months.

Although other factors may contribute to the recent decrease in enrollment, state officials point out the state is now experiencing a more severe effect on enrollment than it has following any of the Medicaid changes that have occurred over the past several years. The state's conclusion that the citizenship documentation requirement is driving the decline is supported by the fact that enrollment has dropped among the populations subject to the requirement (children and families) but has remained steady among groups not affected by the requirement (individuals receiving Medicare and SSI).

Louisiana: In two months—September and October of 2006—Louisiana experienced a net loss of more than 7,500 children in its Medicaid program despite a vigorous back-to-school outreach effort and a significant increase in applications during the month of September.

According to state officials, the enrollment decline is not driven by population loss from Hurricane Katrina and contrasts dramatically with enrollment spikes that usually occur in September and have reached up to 13,000 in the past. The reason for the drop-off is two-fold, according to the state: for some people, Medicaid is being denied or terminated because they have not presented the required citizenship or identity documents. In addition, the additional workload generated by the new requirement is diverting the time and effort eligibility workers normally would spend on activities to ensure that Medicaid beneficiaries do not lose coverage at renewal.

Virginia: Since July, enrollment of children in the state's Medicaid program has declined steadily each month. By the end of November, the total net decline stood at close to 12,000 children. During the same period, enrollment of children in the state's separate SCHIP program, not subject to the new requirement, increased. Virginia also reported a substantial backlog in application processing at its central processing site, with 2,600 cases pending approval for Medicaid in September, when normally no more than 50 such cases are pending at the end of a month.

After the plunge in children's Medicaid enrollment over several months, a small increase occurred in December 2006 (although Medicaid enrollment for children then began dropping again in January). State officials say the December ''up-tick'' suggests that some families are finally ''getting over the hurdles'' imposed by the new law and children (who were eligible at the time they applied but lacked the required documentation) are getting health coverage after a significant delay during which they were without coverage.

New Hampshire: Data from the New Hampshire Healthy Kids Program, a private organization that processes mail-in applications for the state's Medicaid and SCHIP programs, indicate that the percentage of applications submitted with all necessary documents in September of this year dropped by almost half compared to the percentage of complete applications submitted in September 2005. If applicants do not supply missing documentation within 28 days, New Hampshire closes the application. The percentage of applications closed due to missing documents has also increased significantly: from around 10 percent of applications before the new requirement to 20 percent in August 2006. In addition, New Hampshire Healthy Kids reports that between June 2006 and September 2006, enrollment of children in Medicaid dropped by 1,275.

IMPACT ON STATE ADMINISTRATIVE COSTS

Data on state Medicaid administrative costs for the months since July 1 are not available from CMS or any other national source. Several states, however, have examined the impact of the new Medicaid citizenship documentation requirement on their administrative expenditures. Their findings are as follows:

Illinois: Illinois is projecting $16 million to $19 million in increased staffing costs in the first year of implementation of the requirement.

Arizona: The Arizona legislature has allocated $10 million to implement the citizenship documentation requirement. This included the costs associated with staffing, training and payments for obtaining birth records.

Colorado: The FY07–08 budget request for the Colorado Department of Health Care Policy and Financing includes a request for an additional $2.8 million for county administration costs. This request is based on an assumption by the Centers for Medicare and Medicaid Services (CMS) that it will take an additional 5 minutes per application for a caseworker to process citizenship and identity documents. The Department stated in a Joint Budget Committee Hearing that this amount ''may not be sufficient for Colorado counties and special record storage needs.

Washington: Washington State is projecting additional costs associated with hiring 19 additional FTEs in FY07 due to the new requirement, and retaining seven of them in FY08 and FY09. The state estimates that the costs will be $2.7 million on FY07 and $450,000 in each of the succeeding two years.

Wisconsin: Wisconsin is expecting increased costs of $1.8 million to cover the increased workload associated with administering the requirement in FY07 and $600,000 to $700,000 per year for the two years after that.

Minnesota: Minnesota is estimating that it will spend $1.3 million in FY07 for new staff, birth record fees and other administrative expenses.

CONCLUSION

Based on these findings and reports, and strong anecdotal evidence, it seems increasingly clear that the new Medicaid citizenship documentation requirement is having a negative impact on Medicaid enrollment, especially among children. Insufficient information is available to determine the precise extent to which individuals whose Medicaid eligibility has been delayed, denied or terminated are U.S. citizens, eligible legal immigrants, or ineligible immigrants. However, the fact that significant numbers of individuals are being approved for Medicaid after delays of many months, during which they were uninsured, demonstrates that the requirement is adversely affecting substantial numbers of U.S. citizens, especially children who are citizens. Moreover, a large body of research conducted over a number of years has conclusively shown that increasing documentation and other administrative burdens generally results in eligible individuals failing to obtain coverage as a result of the enrollment and renewal processes having become more complicated to understand and more difficult to navigate. Regarding the Medicaid enrollment declines, Anita Smith, Chief of the Bureau of Medical Supports for the Iowa Department of Human Services, has stated: ''There is no evidence that the [enrollment] decline is due to undocumented aliens leaving the program. Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity.''

A number of governors across the nation are announcing their intentions to push new initiatives to cover the uninsured, particularly children. These proposals are being designed to build upon existing public coverage programs, of which Medicaid is the largest, and invariably these proposals call for the enrollment of individuals who are currently eligible for existing programs but remain uninsured. Success will depend, in large measure, on policies and procedures that facilitate rather than frustrate such efforts so that eligible individuals can obtain the benefits for which they qualify. The Medicaid citizenship documentation requirement, which appears to be an extremely blunt instrument, stands to undercut such efforts by placing a daunting administrative obstacle in the way of many low-income U.S. citizens who otherwise have shown that they qualify or by discouraging potentially eligible citizens from applying because the process appears too complex or intimidating. The requirement also appears to be deflecting state human and financial resources away from activities designed to reach eligible children and families and to enroll them in the most efficient and effective manner.

By Mr. KENNEDY (for himself, Mr. DODD, Mr. HARKIN, Ms. MIKULSKI, Mrs. MURRAY, Mrs. CLINTON, Mr. OBAMA, Mr. SANDERS, Mr. BROWN, Mr. DURBIN, Mr. INOUYE, Mr. BIDEN, Mr. LEVIN, Mr. KERRY, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mr. AKAKA, Mrs. BOXER, Mr. FEINGOLD, Mr. SCHUMER, Mr. LAUTENBERG, Mr. MENENDEZ, and Mr. CASEY):

S. 910. A bill to provide for paid sick leave to ensure that Americans can address their own health needs and the health needs of their families; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President day in and day out across America, millions of men and women go to work in jobs that are the backbone of our economy. They make our country great and prosperous. They work hard to provide for their families and care for them.

Often, however, they have to miss days of work because of illness. Every parent knows what it's like to care for a sick child, and every child knows the importance of a parent taking care of them when they are ill. Yet, every day, countless Americans find their paychecks or even their jobs at risk when illness strikes.

As Members of Congress, we don't lose our pay or risk our jobs if we stay home because of illness. But millions of our fellow citizens are not so fortunate.

Mr. President, 57 million Americans—nearly half of all private-sector workers in the United States—do not have paid sick days. Seventy percent don't have paid sick days they can use to care for family members. They can't take a day off to recover from the flu. They can't leave work to care for a child who is running a fever.

Among workers in the lowest income quarter, the numbers are even worse—percent do not have the right to take time off for illness without losing their payor even their jobs.

This lack of protection is especially difficult for working women with children. Women have moved into the workforce in record numbers, but they continue to have primary responsibility for their children's health. Nearly 80 percent of mothers say they are solely responsible for their children's medical care. Yet they can't take a day off to care for a sick child.

If we truly care about families, we have to change those facts. Americans want to be responsible employees and responsible parents. We need workplace laws that allow workers the time needed to care for themselves or family members when they are sick without losing payor risking their jobs.

That is why today I am introducing the Healthy Families Act, to give American workers up to seven paid days of sick leave a year. Now Congresswoman ROSA DELAURO is introducing the legislation in the House of Representatives.

Earlier this week, she and I met with hundreds of workers and parents from around the country, representing tens of thousands of parents asking Congress to take action.

I am talking about hard-working people such as Bertha Brown, who spoke to hundreds of us in front of the Capitol. Bertha is a home healthcare aide. She has spent her life caring for America's sick and elderly, yet she herself has no paid sick days to care for herself or her children. She told us how she had to leave her sick daughter at home when she went to work.

Paid sick days aren't just a family issue—they are also a public health issue. When sick people go to work, they are likely to infect their coworkers and the public. Every day, we hear reports of stomach illnesses breaking out in restaurants or on cruise ships. We learn of flu outbreaks leading to hospitalization of the elderly. Such illnesses are contagious, but their spread can be minimized if sick people stay at home.

However, a high proportion of workers who have constant contact with the public have no paid sick days—85 percent of food service workers and 55 percent of workers in the retail industry are denied that benefit; 30 percent of health care workers can't take paid time off when they are ill.

That is why nurses and doctors support paid sick days. When our Health Committee held a hearing on this issue last month, we heard from pediatricians at Boston Children's Hospital and a public health expert in San Francisco about the significant health benefits and reduction of medical costs that result from paid sick days. We all know that preventive care helps reduce medical costs. Giving people the opportunity to obtain medical treatment for illnesses or chronic medical conditions before their conditions worsen is common sense.

Paid sick days also are important to help children stay healthy and in school so that they can learn. When sick children go to school, they don't learn well, and they are likely to infect their fellow students.

We also heard this week from Carolyn Duff, a nurse in an elementary school in South Carolina. She treated a fifth grader she suspected had strep throat. His parents did not have paid sick days and could not take him to the doctor. After 4 days, his condition worsened. He developed scarlet fever and a rash covered his entire body—all because his parents, for fear of losing their jobs, weren't able to take time off to care for him. As Carolyn Duff said, the child not only suffered without the care of his parents, he also lost 10 precious days of his studies at school.

Paid sick days will result in significant savings to our economy and our health care system. That is why employers support paid sick days too. Dancing Deer Bakery—a small business Boston—sent me a letter making this important point:

> A national paid sick days law creates a level playing field for all businesses. . . . We hope that a bill will move through both Chambers and be on the President's desk. Paid sick days should be a non-partisan issue. A healthy nation is a productive nation.

Paid sick days are good for families, good for our public health, and good for our economy. Our people have waited long enough for this need to be met. It is time to pass the Healthy Families Act.

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

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

S. 910

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Healthy Families Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Working Americans need time to meet their own health care needs and to care for family members, including their children, spouse, parents, and parents-in-law, and other children and adults for whom they are caretakers.

(2) Health care needs include preventive health care, diagnostic procedures, medical treatment, and recovery in response to short- and long-term illnesses and injuries.

(3) Providing employees time off to meet health care needs ensures that they will be healthier in the long run. Preventive care helps avoid illnesses and injuries and routine medical care helps detect illnesses early and shorten their duration.

(4) When parents are available to care for their children who become sick, children recover faster, more serious illnesses are prevented, and children's overall mental and physical health improve. Parents who cannot afford to miss work and must send children with a contagious illness to child care or school contribute to the high rate of infections in child care centers and schools.

(5) Providing paid sick leave improves public health by reducing infectious disease. Policies that make it easier for sick adults and children to be isolated at home reduce the spread of infectious disease.

(6) Routine medical care reduces medical costs by detecting and treating illness and injury early, decreasing the need for emergency care. These savings benefit public and private payers of health insurance, including private businesses.

(7) The provision of individual and family sick leave by large and small businesses, both here in the United States and elsewhere, demonstrates that policy solutions are both feasible and affordable in a competitive economy. Measures that ensure that employees are in good health and do not need to worry about unmet family health problems help businesses by promoting productivity and reducing employee turnover.

(8) The American Productivity Audit found that presenteeism—the practice of employees coming to work despite illness—costs $180,000,000,000 annually in lost productivity. Studies in the Journal of Occupational and Environmental Medicine, the Employee Benefit News, and the Harvard Business Review show that presenteeism is a larger productivity drain than either absenteeism or short-term disability.

(9) The absence of paid sick leave has forced Americans to make untenable choices between needed income and jobs on the one hand and caring for their own and their family's health on the other.

(10) Nearly half of Americans lack paid leave for self-care or to care for a family member. For families in the lowest quartile of earners, 79 percent lack paid sick leave. For families in the next 2 quartiles, 46 and 38 percent, respectively, lack paid sick leave. Even for families in the highest income quartile, 28 percent lack paid sick leave. In addition, millions of workers cannot use paid sick leave to care for ill family members.

(11) Due to the roles of men and women in society, the primary responsibility for family caretaking often falls on women, and such responsibility affects the working lives of women more than it affects the working lives of men.

(12) An increasing number of men are also taking on caretaking obligations, and men who request leave time for caretaking purposes are often denied accommodation or penalized because of stereotypes that caretaking is only ''women's work''.

(13) Employers' reliance on persistent stereotypes about the ''proper'' roles of both men and women in the workplace and in the home continues a cycle of discrimination and fosters stereotypical views about women's commitment to work and their value as employees.

(14) Employment standards that apply to only one gender have serious potential for encouraging employers to discriminate against employees and applicants for employment who are of that gender.

(15) It is in the national interest to ensure that all Americans can care for their own health and the health of their families while prospering at work.

SEC. 3. PURPOSES.

The purposes of this Act are—

(1) to ensure that all working Americans can address their own health needs and the health needs of their families by requiring employers to provide a minimum level of paid sick leave including leave for family care;

(2) to diminish public and private health care costs by enabling workers to seek early and routine medical care for themselves and their family members;

(3) to accomplish the purposes described in paragraphs (1) and (2) in a manner that is feasible for employers; and

(4) consistent with the provision of the 14th amendment to the Constitution relating to equal protection of the laws, and pursuant to Congress' power to enforce that provision under section 5 of that amendment—

(A) to accomplish the purposes described in paragraphs (1) and (2) in a manner that minimizes the potential for employment discrimination on the basis of sex by ensuring generally that leave is available for eligible medical reasons on a gender-neutral basis; and

(B) to promote the goal of equal employment opportunity for women and men.

SEC. 4. DEFINITIONS.

In this Act:

(1) CHILD.—The term ''child'' means a biological, foster, or adopted child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is—

(A) under 18 years of age; or

(B) 18 years of age or older and incapable of self-care because of a mental or physical disability.

(2) EMPLOYEE.—The term ''employee'' means an individual—

(A) who is—

(i)(I) an employee, as defined in section 3(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(e)), who is not covered under clause (v), including such an employee of the Library of Congress, except that a reference in such section to an employer shall be considered to be a reference to an employer described in clauses (i)(I) and (ii) of paragraph (3)(A); or

(II) an employee of the Government Accountability Office;

(ii) a State employee described in section 304(a) of the Government Employee Rights Act of 1991 (42 U.S.C. 2000e–16c(a));

(iii) a covered employee, as defined in section 101 of the Congressional Accountability Act of 1995 (2 U.S.C. 1301), other than an applicant for employment;

(iv) a covered employee, as defined in section 411(c) of title 3, United States Code; or

(v) a Federal officer or employee covered under subchapter V of chapter 63 of title 5, United States Code; and

(B) who works an average of at least 20 hours per week or, in the alternative, at least 1,000 hours per year.

(3) EMPLOYER.—

(A) IN GENERAL.—The term ''employer'' means a person who is—

(i)(I) a covered employer, as defined in subparagraph (B), who is not covered under subclause (V);

(II) an entity employing a State employee described in section 304(a) of the Government Employee Rights Act of 1991;

(III) an employing office, as defined in section 101 of the Congressional Accountability Act of 1995;

(IV) an employing office, as defined in section 411(c) of title 3, United States Code; or

(V) an employing agency covered under subchapter V of chapter 63 of title 5, United States Code; and

(ii) is engaged in commerce (including government), in the production of goods for commerce, or in an enterprise engaged in commerce (including government) or in the production of goods for commerce.

(B) COVERED EMPLOYER.—

(i) IN GENERAL.—In subparagraph (A)(i)(I), the term ''covered employer''—

(I) means any person engaged in commerce or in any industry or activity affecting commerce who employs 15 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year;

(II) includes—

(aa) any person who acts, directly or indirectly, in the interest of an employer to any of the employees of such employer; and

(bb) any successor in interest of an employer;

(III) includes any ''public agency'', as defined in section 3(x) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(x)); and

(IV) includes the Government Accountability Office and the Library of Congress.

(ii) PUBLIC AGENCY.—For purposes of clause (i)(III), a public agency shall be considered to be a person engaged in commerce or in an industry or activity affecting commerce.

(iii) DEFINITIONS.—For purposes of this subparagraph:

(I) COMMERCE.—The terms ''commerce'' and ''industry or activity affecting commerce'' mean any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and include ''commerce'' and any ''industry affecting commerce'', as defined in paragraphs (1) and (3) of section 501 of the Labor Management Relations Act, 1947 (29 U.S.C. 142 (1) and (3)).

(II) EMPLOYEE.—The term ''employee'' has the same meaning given such term in section 3(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(e)).

(III) PERSON.—The term ''person'' has the same meaning given such term in section 3(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(a)).

(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(4) EMPLOYMENT BENEFITS.—The term ''employment benefits'' means all benefits provided or made available to employees by an employer, including group life insurance, health insurance, disability insurance, sick leave, annual leave, educational benefits, and pensions, regardless of whether such benefits are provided by a practice or written policy of an employer or through an ''employee benefit plan'', as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3)).

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means a provider who—

(A)(i) is a doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

(ii) is any other person determined by the Secretary to be capable of providing health care services; and

(B) is not employed by an employer for whom the provider issues certification under this Act.

(6) PARENT.—The term ''parent'' means a biological, foster, or adoptive parent of an employee, a stepparent of an employee, or a legal guardian or other person who stood in loco parentis to an employee when the employee was a child.

(7) PRO RATA.—The term ''pro rata'', with respect to benefits offered to part-time employees, means the proportion of each of the benefits offered to full-time employees that are offered to part-time employees that, for each benefit, is equal to the ratio of part-time hours worked to full-time hours worked.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(9) SICK LEAVE.—The term ''sick leave'' means an increment of compensated leave provided by an employer to an employee as a benefit of employment for use by the employee during an absence from employment for any of the reasons described in paragraphs (1) through (3) of section 5(d).

(10) SPOUSE.—The term ''spouse'', with respect to an employee, has the meaning given such term by the marriage laws of the State in which the employee resides.

SEC. 5. PROVISION OF PAID SICK LEAVE.

(a) IN GENERAL.—An employer shall provide for each employee employed by the employer not less than—

(1) 7 days of sick leave with pay and employment benefits annually for employees working 30 or more hours per week; or

(2) a pro rata number of days or hours of sick leave with pay and employment benefits annually for employees working less than—

(A) 30 hours per week on a year-round basis; or

(B) 1,500 hours throughout the year involved.

(b) ACCRUAL.—

(1) PERIOD OF ACCRUAL.—Sick leave provided for under this section shall accrue as determined appropriate by the employer, but not on less than a quarterly basis.

(2) ACCUMULATION.—Accrued sick leave provided for under this section shall carry over from year to year, but this Act shall not be construed to require an employer to permit an employee to accumulate more than 7 days of the sick leave.

(3) USE.—The sick leave may be used as accrued. The employer, at the discretion of the employer, may loan the sick leave to the employee in advance of accrual by such employee.

(c) CALCULATION.—

(1) LESS THAN A FULL WORKDAY.—Unless the employer and employee agree to designate otherwise, for periods of sick leave that are less than a normal workday, that leave shall be counted—

(A) on an hourly basis; or

(B) in the smallest increment that the employer's payroll system uses to account for absences or use of leave.

(2) VARIABLE SCHEDULE.—If the schedule of an employee varies from week to week, a weekly average of the hours worked over the 12-week period prior to the beginning of a sick leave period shall be used to calculate the employee's normal workweek for the purpose of determining the amount of sick leave to which the employee is entitled.

(d) USES.—Sick leave accrued under this section may be used by an employee for any of the following:

(1) An absence resulting from a physical or mental illness, injury, or medical condition of the employee.

(2) An absence resulting from obtaining professional medical diagnosis or care, or preventive medical care, for the employee subject to the requirement of subsection (e).

(3) An absence for the purpose of caring for a child, a parent, a spouse, or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship, who—

(A) has any of the conditions or needs for diagnosis or care described in paragraph (1) or (2); and

(B) in the case of someone who is not a child, is otherwise in need of care.

(e) SCHEDULING.—An employee shall make a reasonable effort to schedule leave under paragraphs (2) and (3) of subsection (d) in a manner that does not unduly disrupt the operations of the employer.

(f) PROCEDURES.—

(1) IN GENERAL.—Paid sick leave shall be provided upon the oral or written request of an employee. Such request shall—

(A) include a reason for the absence involved and the expected duration of the leave;

(B) in a case in which the need for leave is foreseeable at least 7 days in advance of such leave, be provided at least 7 days in advance of such leave; and

(C) otherwise, be provided as soon as practicable after the employee is aware of the need for such leave.

(2) CERTIFICATION.—

(A) PROVISION.—

(i) IN GENERAL.—Subject to subparagraph (C), an employer may require that a request for leave be supported by a certification issued by the health care professional of the eligible employee or of an individual described in subsection (d)(3), as appropriate, if the leave period covers more than 3 consecutive workdays.

(ii) TIMELINESS.—The employee shall provide a copy of such certification to the employer in a timely manner, not later than 30 days after the first day of the leave. The employer shall not delay the commencement of the leave on the basis that the employer has not yet received the certification.

(B) SUFFICIENT CERTIFICATION.—

(i) IN GENERAL.—A certification provided under subparagraph (A) shall be sufficient if it states—

(I) the date on which the leave will be needed;

(II) the probable duration of the leave;

(III) the appropriate medical facts within the knowledge of the health care provider regarding the condition involved, subject to clause (ii); and

(IV)(aa) for purposes of leave under subsection (d)(1), a statement that leave from work is medically necessary;

(bb) for purposes of leave under subsection (d)(2), the dates on which testing for a medical diagnosis or care is expected to be given and the duration of such testing or care; and

(cc) for purposes of leave under subsection (d)(3), in the case of leave to care for someone who is not a child, a statement that care is needed for an individual described in such subsection, and an estimate of the amount of time that such care is needed for such individual.

(ii) LIMITATION.—In issuing a certification under subparagraph (A), a health care provider shall make reasonable efforts to limit the medical facts described in clause (i)(III) that are disclosed in the certification to the minimum necessary to establish a need for the employee to utilize paid sick leave.

(C) REGULATIONS.—Regulations prescribed under section 13 shall specify the manner in which an employee who does not have health insurance shall provide a certification for purposes of this paragraph.

(D) CONFIDENTIALITY AND NONDISCLOSURE.—

(i) PROTECTED HEALTH INFORMATION.—Nothing in this Act shall be construed to require a health care provider to disclose information in violation of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) or the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note).

(ii) HEALTH INFORMATION RECORDS.—If an employer possesses health information about an employee or an employee's child, parent, spouse or other individual described in subsection (d)(3), such information shall—

(I) be maintained on a separate form and in a separate file from other personnel information;

(II) be treated as a confidential medical record; and

(III) not be disclosed except to the affected employee or with the permission of the affected employee.

(g) CURRENT LEAVE POLICIES.—

(1) EQUIVALENCY REQUIREMENT.—An employer with a leave policy providing paid leave options shall not be required to modify such policy, if such policy includes provisions for the provision, use, and administration of paid sick leave that meet the requirements of subsections (a) through (f).

(2) NO ELIMINATION, REDUCTION, OR REDESIGNATION OF EXISTING LEAVE.—An employer may not eliminate, reduce, or redesignate any leave in existence on the date of enactment of this Act in order to comply with the provisions of this Act.

SEC. 6. POSTING REQUIREMENT.

(a) IN GENERAL.—Each employer shall post and keep posted a notice, to be prepared or approved in accordance with procedures specified in regulations prescribed under section 13, setting forth excerpts from, or summaries of, the pertinent provisions of this Act including—

(1) information describing leave available to employees under this Act;

(2) information pertaining to the filing of an action under this Act;

(3) the details of the notice requirement for foreseeable leave under section 5(f)(1)(B); and

(4) information that describes—

(A) the protections that an employee has in exercising rights under this Act; and

(B) how the employee can contact the Secretary (or other appropriate authority as described in section 8) if any of the rights are violated.

(b) LOCATION.—The notice described under subsection (a) shall be posted—

(1) in conspicuous places on the premises of the employer, where notices to employees (including applicants) are customarily posted; or

(2) in employee handbooks.

(c) VIOLATION; PENALTY.—Any employer who willfully violates the posting requirements of this section shall be subject to a civil fine in an amount not to exceed $100 for each separate offense.

SEC. 7. PROHIBITED ACTS.

(a) INTERFERENCE WITH RIGHTS.—

(1) EXERCISE OF RIGHTS.—It shall be unlawful for any employer to interfere with, restrain, or deny the exercise of, or the attempt to exercise, any right provided under this Act, including—

(A) discharging or discriminating against (including retaliating against) any individual, including a job applicant, for exercising, or attempting to exercise, any right provided under this Act;

(B) using the taking of sick leave under this Act as a negative factor in an employment action, such as hiring, promotion, or a disciplinary action; or

(C) counting the sick leave under a no-fault attendance policy.

(2) DISCRIMINATION.—It shall be unlawful for any employer to discharge or in any other manner discriminate against (including retaliating against) any individual, including a job applicant, for opposing any practice made unlawful by this Act.

(b) INTERFERENCE WITH PROCEEDINGS OR INQUIRIES.—It shall be unlawful for any person to discharge or in any other manner discriminate against (including retaliating against) any individual, including a job applicant, because such individual—

(1) has filed an action, or has instituted or caused to be instituted any proceeding, under or related to this Act;

(2) has given, or is about to give, any information in connection with any inquiry or proceeding relating to any right provided under this Act; or

(3) has testified, or is about to testify, in any inquiry or proceeding relating to any right provided under this Act.

(c) CONSTRUCTION.—Nothing in this section shall be construed to state or imply that the scope of the activities prohibited by section 105 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2615) is less than the scope of the activities prohibited by this section.

SEC. 8. ENFORCEMENT AUTHORITY.

(a) IN GENERAL.—

(1) DEFINITION.—In this subsection:

(A) the term ''employee'' means an employee described in clause (i) or (ii) of section 4(2)(A); and

(B) the term ''employer'' means an employer described in subclause (I) or (II) of section 4(3)(A)(i).

(2) INVESTIGATIVE AUTHORITY.—

(A) IN GENERAL.—To ensure compliance with the provisions of this Act, or any regulation or order issued under this Act, the Secretary shall have, subject to subparagraph (C), the investigative authority provided under section 11(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(a)), with respect to employers, employees, and other individuals affected.

(B) OBLIGATION TO KEEP AND PRESERVE RECORDS.—An employer shall make, keep, and preserve records pertaining to compliance with this Act in accordance with section 11(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(c)) and in accordance with regulations prescribed by the Secretary.

(C) REQUIRED SUBMISSIONS GENERALLY LIMITED TO AN ANNUAL BASIS.—The Secretary shall not require, under the authority of this paragraph, an employer to submit to the Secretary any books or records more than once during any 12-month period, unless the Secretary has reasonable cause to believe there may exist a violation of this Act or any regulation or order issued pursuant to this Act, or is investigating a charge pursuant to paragraph (4).

(D) SUBPOENA AUTHORITY.—For the purposes of any investigation provided for in this paragraph, the Secretary shall have the subpoena authority provided for under section 9 of the Fair Labor Standards Act of 1938 (29 U.S.C. 209).

(3) CIVIL ACTION BY EMPLOYEES OR INDIVIDUALS.—

(A) RIGHT OF ACTION.—An action to recover the damages or equitable relief prescribed in subparagraph (B) may be maintained against any employer in any Federal or State court of competent jurisdiction by one or more employees or individuals or their representative for and on behalf of—

(i) the employees or individuals; or

(ii) the employees or individuals and others similarly situated.

(B) LIABILITY.—Any employer who violates section 7 (including a violation relating to rights provided under section 5) shall be liable to any employee or individual affected—

(i) for damages equal to—

(I) the amount of—

(aa) any wages, salary, employment benefits, or other compensation denied or lost by reason of the violation; or

(bb) in a case in which wages, salary, employment benefits, or other compensation have not been denied or lost, any actual monetary losses sustained as a direct result of the violation up to a sum equal to 7 days of wages or salary for the employee or individual;

(II) the interest on the amount described in subclause (I) calculated at the prevailing rate; and

(III) an additional amount as liquidated damages; and

(ii) for such equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(C) FEES AND COSTS.—The court in an action under this paragraph shall, in addition to any judgment awarded to the plaintiff, allow a reasonable attorney's fee, reasonable expert witness fees, and other costs of the action to be paid by the defendant.

(4) ACTION BY THE SECRETARY.—

(A) ADMINISTRATIVE ACTION.—The Secretary shall receive, investigate, and attempt to resolve complaints of violations of section 7 (including a violation relating to rights provided under section 5) in the same manner that the Secretary receives, investigates, and attempts to resolve complaints of violations of sections 6 and 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206 and 207).

(B) CIVIL ACTION.—The Secretary may bring an action in any court of competent jurisdiction to recover the damages described in paragraph (3)(B)(i).

(C) SUMS RECOVERED.—Any sums recovered by the Secretary pursuant to subparagraph (B) shall be held in a special deposit account and shall be paid, on order of the Secretary, directly to each employee or individual affected. Any such sums not paid to an employee or individual affected because of inability to do so within a period of 3 years shall be deposited into the Treasury of the United States as miscellaneous receipts.

(5) LIMITATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an action may be brought under paragraph (3), (4), or (6) not later than 2 years after the date of the last event constituting the alleged violation for which the action is brought.

(B) WILLFUL VIOLATION.—In the case of an action brought for a willful violation of section 7 (including a willful violation relating to rights provided under section 5), such action may be brought within 3 years of the date of the last event constituting the alleged violation for which such action is brought.

(C) COMMENCEMENT.—In determining when an action is commenced under paragraph (3), (4), or (6) for the purposes of this paragraph, it shall be considered to be commenced on the date when the complaint is filed.

(6) ACTION FOR INJUNCTION BY SECRETARY.—The district courts of the United States shall have jurisdiction, for cause shown, in an action brought by the Secretary—

(A) to restrain violations of section 7 (including a violation relating to rights provided under section 5), including the restraint of any withholding of payment of wages, salary, employment benefits, or other compensation, plus interest, found by the court to be due to employees or individuals eligible under this Act; or

(B) to award such other equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(7) SOLICITOR OF LABOR.—The Solicitor of Labor may appear for and represent the Secretary on any litigation brought under paragraph (4) or (6).

(8) GOVERNMENT ACCOUNTABILITY OFFICE AND LIBRARY OF CONGRESS.—Notwithstanding any other provision of this subsection, in the case of the Government Accountability Office and the Library of Congress, the authority of the Secretary of Labor under this subsection shall be exercised respectively by the Comptroller General of the United States and the Librarian of Congress.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—The powers, remedies, and procedures provided in the Congressional Accountability Act of 1995 (2 U.S.C. 1301 et seq.) to the Board (as defined in section 101 of that Act (2 U.S.C. 1301)), or any person, alleging a violation of section 202(a)(1) of that Act (2 U.S.C. 1312(a)(1)) shall be the powers, remedies, and procedures this Act provides to that Board, or any person, alleging an unlawful employment practice in violation of this Act against an employee described in section 4(2)(A)(iii).

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—The powers, remedies, and procedures provided in chapter 5 of title 3, United States Code, to the President, the Merit Systems Protection Board, or any person, alleging a violation of section 412(a)(1) of that title, shall be the powers, remedies, and procedures this Act provides to the President, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this Act against an employee described in section 4(2)(A)(iv).

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—The powers, remedies, and procedures provided in title 5, United States Code, to an employing agency, provided in chapter 12 of that title to the Merit Systems Protection Board, or provided in that title to any person, alleging a violation of chapter 63 of that title, shall be the powers, remedies, and procedures this Act provides to that agency, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this Act against an employee described in section 4(2)(A)(v).

SEC. 9. COLLECTION OF DATA ON PAID SICK DAYS AND FURTHER STUDY.

(a) COMPILATION OF INFORMATION.—Effective 90 days after the date of enactment of this Act, the Commissioner of Labor Statistics shall annually compile information on the following:

(1) The number of employees who used paid sick leave.

(2) The number of hours of the paid sick leave used.

(3) The demographic characteristics of employees who were eligible for and who used the paid sick leave.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall annually conduct a study to determine the following:

(A)(i) The number of days employees used paid sick leave and the reasons for the use.

(ii) The number of employees who used the paid sick leave for leave periods covering more than 3 consecutive workdays.

(B) Whether employees used the paid sick leave to care for illnesses or conditions caused by domestic violence against the employees or their family members.

(C) The cost and benefits to employers of implementing the paid sick leave policies.

(D) The cost to employees of providing certification issued by a health care provider to obtain the paid sick leave.

(E) The benefits of the paid sick leave to employees and their family members, including effects on employees' ability to care for their family members or to provide for their own health needs.

(F) Whether the paid sick leave affected employees' ability to sustain an adequate income while meeting health needs of the employees and their family members.

(G) Whether employers who administered paid sick leave policies prior to the date of enactment of this Act were affected by the provisions of this Act.

(H) Whether other types of leave were affected by this Act.

(I) Whether paid sick leave affected retention and turnover and costs of presenteeism.

(J) Whether the paid sick leave increased the use of less costly preventive medical care and lowered the use of emergency room care.

(K) Whether the paid sick leave reduced the number of children sent to school when the children were sick.

(2) AGGREGATING DATA.—The data collected under subparagraphs (A), (B), and (E) of paragraph (1) shall be aggregated by gender, race, disability, earnings level, age, marital status, and family type, including parental status.

(3) REPORTS.—

(A) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the appropriate committees of Congress concerning the results of the study conducted pursuant to paragraph (1) and the data aggregated under paragraph (2).

(B) FOLLOWUP REPORT.—Not later that 5 years after the date of enactment of this Act the Comptroller General of the United States shall prepare and submit a followup report to

the appropriate committees of Congress concerning the results of the study conducted pursuant to paragraph (1) and the data aggregated under paragraph (2).

SEC. 10. EFFECT ON OTHER LAWS.

(a) FEDERAL AND STATE ANTIDISCRIMINATION LAWS.—Nothing in this Act shall be construed to modify or affect any Federal or State law prohibiting discrimination on the basis of race, religion, color, national origin, sex, age, or disability.

(b) STATE AND LOCAL LAWS.—Nothing in this Act shall be construed to supersede any provision of any State or local law that provides greater paid sick leave or other leave rights than the rights established under this Act.

SEC. 11. EFFECT ON EXISTING EMPLOYMENT BENEFITS.

(a) MORE PROTECTIVE.—Nothing in this Act shall be construed to diminish the obligation of an employer to comply with any contract, collective bargaining agreement, or any employment benefit program or plan that provides greater paid sick leave rights to employees or individuals than the rights established under this Act.

(b) LESS PROTECTIVE.—The rights established for employees under this Act shall not be diminished by any contract, collective bargaining agreement, or any employment benefit program or plan.

SEC. 12. ENCOURAGEMENT OF MORE GENEROUS LEAVE POLICIES.

Nothing in this Act shall be construed to discourage employers from adopting or retaining leave policies more generous than policies that comply with the requirements of this Act.

SEC. 13. REGULATIONS.

(a) IN GENERAL.—

(1) AUTHORITY.—Except as provided in paragraph (2), not later than 120 days after the date of enactment of this Act, the Secretary shall prescribe such regulations as are necessary to carry out this Act with respect to employees described in clause (i) or (ii) of section 4(2)(A) and other individuals affected by employers described in subclause (I) or (II) of section 4(3)(A)(i).

(2) GOVERNMENT ACCOUNTABILITY OFFICE; LIBRARY OF CONGRESS.—The Comptroller General of the United States and the Librarian of Congress shall prescribe the regulations with respect to employees of the Government Accountability Office and the Library of Congress, respectively and other individuals affected by the Comptroller General of the United States and the Librarian of Congress, respectively.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Board of Directors of the Office of Compliance shall prescribe (in accordance with section 304 of the Congressional Accountability Act of 1995 (2 U.S.C. 1384)) such regulations as are necessary to carry out this Act with respect to employees described in section 4(2)(A)(iii) and other individuals affected by employers described in section 4(3)(A)(i)(III).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this Act except insofar as the Board may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the President (or the designee of the President) shall prescribe such regulations as are necessary to carry out this Act with respect to employees described in section 4(2)(A)(iv) and other individuals affected by employers described in section 4(3)(A)(i)(IV).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this Act except insofar as the President (or designee) may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Director of the Office of Personnel Management shall prescribe such regulations as are necessary to carry out this Act with respect to employees described in section 4(2)(A)(v) and other individuals affected by employers described in section 4(3)(A)(i)(V).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this Act except insofar as the Director may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

SEC. 14. EFFECTIVE DATES.

(a) IN GENERAL.—This Act shall take effect 1 year after the date of issuance of regulations under section 13(a)(1).

(b) COLLECTIVE BARGAINING AGREEMENTS.—In the case of a collective bargaining agreement in effect on the effective date prescribed by subsection (a), this Act shall take effect on the earlier of—

(1) the date of the termination of such agreement; or

(2) the date that occurs 18 months after the date of issuance of regulations under section 13(a)(1).

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 107—EXPRESSING THE SENSE OF THE SENATE THAT NO ACTION SHOULD BE TAKEN TO UNDERMINE THE SAFETY OF THE ARMED FORCES OF THE UNITED STATES OR IMPACT THEIR ABILITY TO COMPLETE THEIR ASSIGNED OR FUTURE MISSIONS

Mrs. MURRAY (for herself and Mr. LEVIN) submitted the following resolution; which was submitted and read:

S. RES. 107

Whereas under the Constitution, the President and Congress have shared responsibilities for decisions on the use of the Armed Forces of the United States, including their mission, and for supporting the Armed Forces, especially during wartime;

Whereas when the Armed Forces are deployed in harm's way, the President, Congress, and the Nation should give them all the support they need in order to maintain their safety and accomplish their assigned or future missions, including the training, equipment, logistics, and funding necessary to ensure their safety and effectiveness, and such support is the responsibility of both the Executive Branch and the Legislative Branch of Government; and

Whereas thousands of members of the Armed Forces who have fought bravely in Iraq and Afghanistan are not receiving the kind of medical care and other support this Nation owes them when they return home: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the President and Congress should not take any action that will endanger the Armed Forces of the United States, and will provide necessary funds for training, equipment, and other support for troops in the field, as such actions will ensure their safety and effectiveness in preparing for and carrying out their assigned missions;

(2) the President, Congress, and the Nation have an obligation to ensure that those who have bravely served this country in time of war receive the medical care and other support they deserve; and

(3) the President and Congress should—

(A) continue to exercise their constitutional responsibilities to ensure that the Armed Forces have everything they need to perform their assigned or future missions; and

(B) review, assess, and adjust United States policy and funding as needed to ensure our troops have the best chance for success in Iraq and elsewhere.

SENATE RESOLUTION 108—DESIGNATING THE FIRST WEEK OF APRIL 2007 AS ''NATIONAL ASBESTOS AWARENESS WEEK''

Mr. BAUCUS (for himself, Mr. REID, Mr. KENNEDY, Mrs. FEINSTEIN, Mr. DURBIN, Mrs. MURRAY, and Mr. LEAHY) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 108

Whereas there is no known safe level of exposure to asbestos;

Whereas deadly asbestos fibers are invisible and cannot be smelled or tasted;

Whereas when a person inhales or swallows airborne asbestos fibers, the damage is permanent and irreversible;

Whereas these fibers can cause mesothelioma, asbestosis, lung cancer, and pleural diseases;

Whereas asbestos-related diseases can take 10 to 50 years to present themselves;

Whereas the expected survival rate of individuals diagnosed with mesothelioma is between 6 and 24 months;

Whereas little is known about late-stage treatment and there is no cure for asbestos-related diseases;

Whereas early detection of asbestos-related diseases would give patients increased treatment options and often improve their prognoses;

Whereas asbestos is a toxic and dangerous substance and must be disposed of properly;

Whereas, in 1977, the International Agency for Research on Cancer classified asbestos as a Category 1 human carcinogen, the highest cancer hazard classification for a substance;

Whereas, in 2002, the United States Geological Survey reported that companies in the United States consumed 9,000 metric tons of asbestos, of which approximately 71 percent was consumed in roofing products, 18 percent in gaskets, 5 percent in friction products, and 6 percent in other products;

Whereas, in 2006, the World Health Organization issued a policy paper, and the International Labour Organization adopted a resolution, agreeing that all forms of asbestos