

These places provided care, often rudimentary, and often carried a stigma. Accommodations were sparse at best. In return for health care and housing, residents were expected to work in the adjoining farm or do housework or other menial labor to offset the cost of their stay.

This was the primary option for someone whose extended family couldn't provide help or didn't want to—right here in the USA. Few Americans today remember those days.

When President Johnson submitted his message to Congress 50 years ago today, fewer than half of America's elderly even had health insurance. In that era, and it wasn't that long ago, it wasn't uncommon for the sick elderly to be treated like second class citizens, and as a result, many aging Americans without family to care for them ended up destitute, without necessary health care, or on the street.

It was a time no one wants to revisit, a time that one sociologist said was "another America" where "40 to 50 million citizens were poor, who lacked adequate medical care, and who were 'socially invisible' to the majority of the population."

It is worth remembering how far we have come. Today, I ask my colleagues to use this anniversary as a vivid reminder of the difference Medicare and Medicaid make in the daily lives of Americans, and also the health care advances that have occurred as a result.

A couple facts to highlight for my colleagues:

Today, with rock-solid essential health services, 54 million Americans—nearly every senior and person with disabilities—has access to Medicare's guarantee.

Meanwhile, Medicaid has made a critical difference for 68 million of the Nation's most vulnerable, including more than 32 million children, 6 million seniors, and 10 million persons with disabilities. Because Medicare and Medicaid made health care possible for millions of people, they have also been the catalyst for innovations in treatment that benefit people of all ages. Here's one example:

In the first 30 years of Medicare alone, deaths from heart disease dropped by a third for people over age 65. By providing coverage and access for millions, these programs became catalysts for changes in how medicine is practiced and paid for, while finding the root causes of disease and perfecting better therapies to treat them.

As time has marched on, these programs evolved and improved, and the rest of the health care system followed.

In 1967, Early and Periodic Screening, Diagnosis, and Treatment, EPSDT, comprehensive health services benefit for all Medicaid children under age 21 was created—helping improve the health of our Nation's kids.

In 1981, home and community-based waivers were established so that states could provide services in a community setting, allowing individuals to remain

in their home for as long as possible. Every state now uses this option to facilitate better care and services to their Medicaid population.

In 1983, Medicare took one of many legs away from fee-for-service with the advent of the hospital prospective payment system, a system that pays hospitals based on a patient's illness, and how serious it was, not based solely on how much it cost to treat them. This change, once considered drastic, has become common place and accepted.

In 2003, the prescription drug coverage was added to Medicare's benefit, providing access to necessary medications for those most likely to need them. As a result of greater access to prescription drugs, beneficiaries' health have dramatically improved.

In 2010, as a result of health reform, preventive services became free to patients, prescription drugs became cheaper for those beneficiaries who fell in the donut hole, Medicare began to move away from purely volume-driven care, and onto paying for quality and value, and the life of the Medicare trust fund was extended.

Finally, in 2012, the Centers for Medicare and Medicaid began releasing loads of claims data for the public to use. Access to this information has been game-changing in understanding the cost of care and variations in the way medicine is practiced across the country.

Today, any of these examples are easy to forget because they are commonplace. But that makes them no less remarkable.

I will close by noting something else, just as striking about Medicare and Medicaid: It was a bipartisan effort. The enactment of these programs shows that Congress can craft bipartisan solutions to very complex and politically difficult problems. That's what happened in 1965 when the Senate passed the legislation creating Medicare and Medicaid by a 68-32 vote after the House approved it three months earlier on a robust 313-115.

As the 114th Congress gets underway, my colleagues and I could all take a page from President Johnson's playbook: Congress shouldn't use partisan tactics when the solutions can be bipartisan.

And there's the lesson; that despite sharp differences and partisanship, the Congress of Johnson's day was able to rise above that culture and those challenges to find agreement and make America a much better place. As this new Congress begins, I hope we can use that 50-year-old spirit to strengthen, protect and improve Medicare and Medicaid to keep the guarantee strong and ensure health care to those who need it most.

SENATE CONCURRENT RESOLUTION 2—AUTHORIZING THE USE OF EMANCIPATION HALL IN THE CAPITOL VISITOR CENTER FOR A CEREMONY TO PRESENT THE CONGRESSIONAL GOLD MEDAL TO THE FIRST SPECIAL SERVICE FORCE, IN RECOGNITION OF ITS SUPERIOR SERVICE DURING WORLD WAR II

Mr. TESTER submitted the following concurrent resolution; which was considered and agreed to:

S. CON. RES. 2

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. USE OF EMANCIPATION HALL FOR CEREMONY TO PRESENT CONGRESSIONAL GOLD MEDAL TO FIRST SPECIAL SERVICE FORCE.

Emancipation Hall in the Capitol Visitor Center is authorized to be used on February 3, 2015, for a ceremony to present the Congressional Gold Medal to the First Special Service Force collectively, in recognition of its superior service during World War II. Physical preparations for the conduct of the ceremony shall be carried out in accordance with such conditions as the Architect of the Capitol may prescribe.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1. Ms. WARREN (for herself and Mr. SCHUMER) proposed an amendment to the bill H.R. 26, to extend the termination date of the Terrorism Insurance Program established under the Terrorism Risk Insurance Act of 2002, and for other purposes.

TEXT OF AMENDMENTS

SA 1. Ms. WARREN (for herself and Mr. SCHUMER) proposed an amendment to the bill H.R. 26, to extend the termination date of the Terrorism Insurance Program established under the Terrorism Risk Insurance Act of 2002, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the "Terrorism Risk Insurance Program Reauthorization Act of 2015".

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title and table of contents.

TITLE I—EXTENSION OF TERRORISM INSURANCE PROGRAM

Sec. 101. Extension of Terrorism Insurance Program.

Sec. 102. Federal share.

Sec. 103. Program trigger.

Sec. 104. Recoupment of Federal share of compensation under the program.

Sec. 105. Certification of acts of terrorism; consultation with Secretary of Homeland Security.

Sec. 106. Technical amendments.

Sec. 107. Improving the certification process.

Sec. 108. GAO study.

Sec. 109. Membership of Board of Governors of the Federal Reserve System.

Sec. 110. Advisory Committee on Risk-Sharing Mechanisms.

Sec. 111. Reporting of terrorism insurance data.