that it will not cut off funds while our troops are in the field.

All the more so will we oppose it when the fight in Iraq, by all accounts, is showing clear-cut tactical progress, and now, at last, some important political progress is also apparent over in Iraq.

This bill does give us an opportunity—an opportunity to step back and highlight the remarkable progress that has been made in Iraq since the first time our friends proposed cutting off funds last May. It gives us a chance to highlight why we were wise to reject it even when the outcome in Iraq was unclear, much less now when progress is clearly being made.

Two months ahead of another visit by General Petraeus and Ambassador Crocker, we should acknowledge the heroic sacrifices of our men and women in uniform and the important turnaround they have achieved in Iraq on behalf of the American people. The brave Iraqis who have stood with them also deserve our praise. All of this is in our Nation's long-term security interests.

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

Mr. REID. Mr. President, I will make a statement prior to the Iraq votes, and I will be happy to lay out why we are doing this. We are doing this because the majority of the American people recognize this war in Iraq is costing huge amounts of money. Some are saying now as much as $15 billion a month.

But let's say it is not that much. Let's say it is only the lower figure of $10 billion to $12 billion a month. I met yesterday with the Speaker and all the 28 Democratic Governors, and they are desperate for money to do what their States need in dealing with health care, infrastructure, and fighting crime. They are desperate. Where is the money they need? It is going to Iraq in the sum of about $400 million a day.

So we are going to continue to debate this because the American people know what is taking place, and I will discuss this more fully right before the votes on the two cloture motions that have been filed on the Iraq situation.

RESERVATION OF LEADER TIME

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

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate resumes consideration of S. 1200, which the clerk will report by title.

The assistant legislative clerk read as follows:

A bill (S. 1200) to amend the Indian Health Care Improvement Act to review and extend that act.

Pending:

Vitter amendment No. 3896 (to amendment No. 3899), to modify a section relating to limitation on use of funds appropriated to the Service.

Dorgan amendment No. 3899, in the nature of a substitute.

Smith amendment No. 3897 (to amendment No. 3899), to modify a provision relating to development of innovative approaches.

Murkowski (for DeMint) amendment No. 4015 (to amendment No. 3899), to authorize the Secretary of Health and Human Services to establish an Indian health savings account demonstration project.

Murkowski (for DeMint) amendment No. 4066 (to amendment No. 3899), of a perfecting nature.

The ACTING PRESIDENT pro tempore. The Senator from North Dakota.

AMENDMENT NO. 3896

Mr. DORGAN. Mr. President, I believe by previous unanimous consent the Senate will now consider the Vitter amendment.

The ACTING PRESIDENT pro tempore. The Senator is correct. There are 2 minutes of debate equally divided.

The Senator from Louisiana.

Mr. VITTER. Mr. President, I strongly urge all of my colleagues to support this mainstream amendment. The Vitter amendment codifies the Hyde amendment and simply says in Indian health care no taxpayer funds will be used to support abortions, with the normal exceptions of the Hyde amendment.

Up to now, this has been the practice and the law, but only because the Indian health care law points to whatever the current appropriations language is on the subject in Labor, Health, and Education. And so it is a very tenuous policy that is subject to change and a vote and a change in policy every year.

This amendment will solidify that policy. It will put the Hyde amendment in permanent Federal authorization law with regard to the Indian health care act, just as was done decades ago in the Defense authorization bill. It is a solid mainstream amendment, and I urge support from both sides of the aisle.

The ACTING PRESIDENT pro tempore. The Senator from North Dakota.

Mr. DORGAN. Mr. President, this is not a debate about whether Federal dollars should be used for abortion services. Current law already prohibits that. I oppose Federal funding for abortions, and I have supported the Hyde provision. But the Vitter amendment is completely unnecessary.

First of all, we have a provision in the underlying bill that relates to the Hyde provision that applies to all other appropriations bills. But I do want to say this: This is not a mainstream amendment that everybody is clear about. In fact, there is a provision in this amendment on page 2, section B. I don't know what it means, and I don't think Senator VITTER knows what it means. There have been no hearings, no discussion, yet onward through the fog on amendments like this.

The fact is, we ought to have a hearing, but there has been no hearing. I don't understand what section B means, nor does the author, I believe.

Having said all that, again, this is not a debate about whether Federal dollars should be used for abortion services. Current law already prohibits the use of Federal funds for abortion services, and the underlying bill contains a provision that relates to current law and continues the same policy.

The ACTING PRESIDENT pro tempore. All time has expired. The Senator from Louisiana.

Mr. VITTER. I ask unanimous consent for 30 additional seconds.

Mr. DORGAN. I will agree, provided I am allowed 30 additional seconds following Senator VITTER.

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

Mr. VITTER. Mr. President, I do this to ask the distinguished Senator about the provision he is talking about. Maybe we can have a discussion about it rather than him vaguely alluding to it without pointing out the language and claiming nobody knows what it means.

Mr. DORGAN. Well, Mr. President, the appropriate place for that kind of discussion would have been a congressional hearing. That is where you discuss what provisions mean and how they are written.

The provision reads: As to provide or pay any administrative cost of any health benefits coverage that includes coverage of an abortion.

I don't understand what that means with respect to facilities or other issues. There are a series of issues that relate to that. And that is not, incidentally, just codifying the Hyde amendment, as the Senator alleges. This provision doesn't exist with the Hyde amendment. This is something the Senator conceived of and added.

My point is, it ought to be the subject of a hearing. We don't disagree on the issue of Federal funding for abortion. We agree on that. But the Senator has mischaracterized his amendment.

Mr. VITTER. Reclaiming my remaining time, that was language I pointed out to the distinguished Senator 3 weeks ago when I introduced my amendment and we discussed it. So I think it is a little disingenuous to bring it up at this point.

Mr. DORGAN. And, Mr. President, he indicated when he pointed it out to me that this is why it was different than the Hyde amendment, which doesn't point to what he claims today.

The ACTING PRESIDENT pro tempore. The question is on agreeing to the amendment.

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

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from New York (Mrs. CLINTON), the Senator from Connecticut (Mr. DODD), and the Senator from Illinois (Mr. OBAMA) are necessarily absent.

Mr. KYL. The following Senators are necessarily absent: the Senator from Texas (Mr. CORNYN), the Senator from Arizona (Mr. MCCAIN), and the Senator from Virginia (Mr. WARNER).

Further, if present and voting, the Senator from Texas (Mr. CORNYN) would have voted ''yea.''

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 42, as follows:

[Rollcall Vote No. 30 Leg.]

YEAS—52

Alexander	DeMint	McConnell
Allard	Dole	Murkowski
Barrasso	Domenici	Nelson (NE)
Bayh	Ensign	Pryor
Bennett	Enzi	Reid
Bond	Graham	Roberts
Brownback	Grassley	Salazar
Bunning	Gregg	Sessions
Burr	Hagel	Shelby
Byrd	Hatch	Smith
Casey	Hutchison	Stevens
Chambliss	Inhofe	Sununu
Coburn	Isakson	Thune
Cochran	Johnson	Vitter
Coleman	Kyl	Voinovich
Corker	Landrieu	Wicker
Craig	Lugar	
Crapo	Martinez	

NAYS—42

Akaka	Feinstein	Mikulski
Baucus	Harkin	Murray
Biden	Inouye	Nelson (FL)
Bingaman	Kennedy	Reed
Boxer	Kerry	Rockefeller
Brown	Klobuchar	Sanders
Cantwell	Kohl	Schumer
Cardin	Lautenberg	Snowe
Carper	Leahy	Specter
Collins	Levin	Stabenow
Conrad	Lieberman	Tester
Dorgan	Lincoln	Webb
Durbin	McCaskill	Whitehouse
Feingold	Menendez	Wyden

NOT VOTING—6

Clinton	Dodd	Obama
Cornyn	McCain	Warner

The amendment (No. 3896) was agreed to.

Mr. DORGAN. I move to reconsider the vote and to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 3897

The ACTING PRESIDENT pro tempore. There will now be 2 minutes of debate equally divided in relation to amendment No. 3897.

The Senator from Oregon.

Mr. SMITH. Mr. President, 8 years ago, Congress asked the Indian Health Service and the tribes to revise a failed system for allocating facilities funding. The compromise they reached may amount to nothing without this amendment. That is why I feel so strongly about it. It is not only about one region or group of regions; this amendment is about holding true the government-to-government relationship the United States holds with all tribes. I ask my colleagues to support the amendment to ensure that all Native Americans receive the health care they need and deserve.

Members should know it is unlikely that Native Americans in their States are receiving construction funding for Indian Health Service facilities. All this does is say to the Indian Health Service: Come up with a formula that is fair. Otherwise, your State, the tribes you represent, will receive nothing.

Mr. BINGAMAN. Mr. President, I rise in opposition to Senator SMITH's amendment, No. 3897, to the Indian Health Care Improvement Act, S. 1200, and urge my fellow Senators to vote against this amendment.

This amendment would expressly authorize the Secretary of Health and Human Services, HHS, to utilize a new ''area distribution fund'' methodology to allocate Indian Health Service, IHS, health care facilities construction, HCFC, funding.

This approach could result in critical projects that are on the current IHS HCFC priority list from receiving funding. These projects have been waiting for many years, and in some cases decades, to receive funding. Furthermore, section 301 of the underlying bill, which the Smith amendment would amend, represents the results of hours of bipartisan negotiations on this issue throughout the last 2 years. While I understand Senator SMITH's desire to provide a possible avenue for his tribes to receive funding, this amendment would undo the very delicate compromise that was reached in the underlying bill.

According to the IHS staff briefings, the entire concept of an area distribution fund does not guarantee that all IHS service areas receive HCFC funding; instead, it creates a new criterion that must be used to determine IHS HCFC funding priorities. The current criteria utilized by IHS are focused on directing funding to the IHS areas in most need, where IHS patients are most isolated and least likely to have access to care. This geographic criterion does not represent good policy but simply an attempt to spread the very paltry funding provided for IHS HCFC projects even more thinly based on location instead of need. Instead of playing games with the distribution formula, we in Congress should be working to ensure that there is adequate funding for IHS HCFC projects so that the current backlog is addressed and new projects from throughout the country may be added.

I note that Navajo Nation also strongly opposes this amendment. The following discussion provides a summary of their concerns.

I. CONGRESS SHOULD LEAVE THE CURRENT LANGUAGE OF SECTION 301 AS CONTAINED WITHIN H.R. 1328 AND S. 1200 UNCHANGED

The current language of section 301 ''grandfathers'' in those health facility projects that have completed phase one and two of the current health care facilities construction priority system, and places them on the construction priority list upon enactment of the Indian Health Care Improvement Act.

The following projects have completed phase one and two of the current health facilities construction funding process: Winslow Dilkon, AZ, Pueblo Pintado, NM, Bodaway-Coppermine, AZ, Gallup Indian Medical Center, NM, Alamo, NM, Albuquerque, NM, Ft. Yuma, AZ, Rapid City, SD, Sells, AZ, Crown Point, NM, and Shiprock, NM. These projects should not be penalized for following the rules by eliminating the old process and instituting a new ill-defined funding system.

II. A LACK OF CONGRESSIONAL FUNDING CREATED CONTROVERSY OVER DISBURSEMENT OF HEALTH FACILITIES CONSTRUCTION DOLLARS

According to the Conference Report for H.R. 2466, the fiscal year 2000 Interior appropriations bill, the managers recognized the need for a ''base funding amount'' for facilities: ''Given the extreme need for new and replacement hospitals and clinics, there should be a base funding amount, which serves as a minimum annual amount in the budget request.'' Unfortunately, the managers' intent was never fulfilled, and funding levels have dropped consistently for several years. Congressional funding for health care facilities construction has decreased from a high of $134,300,000 in fiscal year 1993 to $13 million in fiscal year 2007.

Given the limited amount of funding, tribes are now competing over an ever-decreasing pool of money for tribal health facilities.

III. THE CURRENT SYSTEM RIGHTLY HONORS FUNDING FACILITIES BASED UPON A VOLUME OF SERVICES

Most of the health facility projects on the current priority list have been in the planning process for 20 to 30 years. These projects have done all that is asked of them including adapting to any new requirements imposed on them midway through the planning process.

The current health facilities construction priority system prioritizes projects based on several relevant factors such as volume of services provided; square footage needs; size; age; condition of existing facilities; demographics; population density; isolation; and distance to inpatient, outpatient, and alternative facilities.

The current priority system favors providing health facility construction dollars to those facilities that will provide a large volume of services over 10 years. For example, if a facility will serve 90,000 patient visits a year, calculated over 10 years, then this amount would total 900,000 patient visits in a 10 year period. The current system favors providing a volume of services that provides the most access to health care by the largest pool of people and need.

On the other hand, any system that distributes funding based upon equal distribution among the Indian health care regions could not provide a sufficient volume of services because some regions have larger native populations with less access to health care than others. In other words, fewer people would be provided health care by more facilities.

Keeping the current priority system would provide certainty and reinforce the work put into developing existing health facility projects.

IV. DO NOT AUTHORIZE A VAGUE CONCEPT

There is currently no consensus as to the meaning or impact of an area distribution fund. In fact, the Federal Appropriation Advisory Board, the workgroup created by the IHS to evaluate various facilities construction funding schemes, did not define the area

distribution fund. It is at best only a concept without a set methodology, structure, or any idea of what effects such a change may have on the current funding system. Randall Gardner, Acting Director of the IHS Office of Environmental Health and Engineering, OHE, has referred to the area distribution fund as only a concept in need of further evaluation. It would be the height of irresponsibility for Congress to replace a known system with the uncertainty of a concept without further investigation.

V. THE ISSUE IS ABOUT ACCESS TO HEALTH CARE AND NOT WHETHER TO BUILD ANOTHER HOSPITAL

Some groups have argued that their IHS service areas have not received much needed health facility funding. However, the statistics, when weighed against isolated areas like Sells and the Navajo Nation, do not support the need for another hospital in, for example, the Portland, California, Bemidji, or Nashville service areas. According to the IHS, the Portland area has 218 hospitals providing health services to 157,000 tribal members.

The California, Bemidji, and Nashville areas are similarly situated with respect to health care. In fiscal year 2001, California tribal health programs had 119,362 registered users with 69,238 active users served by 438 hospitals. The Bemidji area comprising Wisconsin, Minnesota, and Michigan, is made up of 34 tribes with 90,000 individual patients served by 494 hospitals. Finally, the Nashville area, which is the largest service area, has a native population of 45,000 Indian people with access to over 1,000 hospitals.

However, the Navajo Nation area, which is as large as West Virginia, has 238,515 users living on, or near, the reservation with access to only 6 hospitals. That is 1 hospital for every 39,753 users. The need for more health care facilities within the Navajo Nation area is clear.

Further, IHS statistics show that while the Portland, California, Bemidji, or Nashville service areas have not received any health facility construction dollars, the native people in these areas have always had access to superior health care. All Native Americans living within IHS areas also do not receive health facility dollars receive contract health care dollars that cover expenses incurred at non-IHS facilities.

The current priority system rewards basic health care access over building redundant hospitals in areas with many non-IHS facilities that can provide much needed health care services. Building another hospital in the Portland, California, Bemidji, or Nashville service areas when the Navajo Nation and other IHS area have significant unmet needs is redundant and inefficient use of federal funds.

VI. CONCLUSION

The current HCFC system now provides funding to ensure that large populations without access to nearby hospitals receive health care facilities funding. The area distribution fund concept has yet to be established with any certainty as to its meaning or impact. A new ill-defined system should not replace the existing priority system without some study. Authorizing such a concept without investigating thoroughly the overall effect of such a dramatic change to how IHS health care facilities funded would be irresponsible.

The ACTING PRESIDENT pro tempore. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I share the frustration of the Senator from Oregon, but I must oppose the amendment. We have a backlog of $3 billion in facilities. If the Secretary chooses to establish what is an area distribution fund, moneys would be taken from the priority list. Many of the tribes on that list have waited a long time for funding for facilities. If the Secretary begins to take money from that priority list and does an area-wide distribution, it would be a serious problem. I want to work with the Senator from Oregon. We desperately need new and improved facilities. We need more money addressed to that. He is raising the right question. I happen to believe it is the wrong answer. I regretfully will vote against it.

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

The ACTING PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 3897. The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from New York (Mrs. CLINTON), the Senator from Connecticut (Mr. DODD), and the Senator from Illinois (Mr. OBAMA) are necessarily absent.

Mr. KYL. The following Senators are necessarily absent: the Senator from Texas (Mr. CORNYN), the Senator from Arizona (Mr. MCCAIN), and the Senator from Virginia (Mr. WARNER).

Further, if present and voting, the Senator from Texas (Mr. CORNYN) would have voted ''yea.''

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 38, as follows:

[Rollcall Vote No. 31 Leg.]

YEAS—56

Akaka	Ensign	Murray
Alexander	Feingold	Pryor
Bennett	Feinstein	Reed
Biden	Gregg	Reid
Bond	Hatch	Roberts
Boxer	Hutchison	Schumer
Brownback	Isakson	Shelby
Byrd	Kennedy	Smith
Cantwell	Kerry	Snowe
Casey	Klobuchar	Specter
Chambliss	Kohl	Stabenow
Cochran	Landrieu	Stevens
Coleman	Lautenberg	Sununu
Collins	Levin	Vitter
Corker	Lincoln	Voinovich
Craig	Lugar	Whitehouse
Crapo	McConnell	Wicker
Dole	Menendez	Wyden
Durbin	Murkowski	

NAYS—38

Allard	Domenici	Martinez
Barrasso	Dorgan	McCaskill
Baucus	Enzi	Mikulski
Bayh	Graham	Nelson (FL)
Bingaman	Grassley	Nelson (NE)
Brown	Hagel	Rockefeller
Bunning	Harkin	Salazar
Burr	Inhofe	Sanders
Cardin	Inouye	Sessions
Carper	Johnson	Tester
Coburn	Kyl	Thune
Conrad	Leahy	Webb
DeMint	Lieberman	

NOT VOTING—6

Clinton	Dodd	Obama
Cornyn	McCain	Warner

The amendment (No. 3897) was agreed to.

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 4015 WITHDRAWN

The ACTING PRESIDENT pro tempore. There will now be 2 minutes of debate in regard to amendment No. 4015.

Mr. DORGAN. Mr. President, we have reached agreement, and I ask unanimous consent that amendment No. 4015 be withdrawn.

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

AMENDMENT NO. 4066

Mr. DORGAN. Mr. President, we have also been in discussions with Senator DEMINT, and we are prepared—and I believe it has been agreed to on both sides—to accept amendment No. 4066 without debate. I ask unanimous consent that the amendment be adopted.

The ACTING PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

The amendment (No. 4066) was agreed to.

Mr. CONRAD. Mr. President, I want to join my colleagues in strong support of the Indian Health Care Improvement Act. Today has been a long time in coming. I want to particularly recognize the work of my friend Senator DORGAN, the chairman of the Indian Affairs Committee. We would not be here today without his dedication and persistence.

In 2004, the U.S. Commission on Civil Rights issued a report on the Native American health care system. One item in the report struck a very somber note with me. The report notes that as early as 1926 the adequacy of the delivery of health care to Native American was formally questioned by the government. In response, a report was issued 2 years later that sparked a host of statements by the Federal Government that the health status of Native Americans was ''intolerable.''

Unfortunately, the Commission notes that much of the 1928 report remains true today. It is indeed sad that in the 21st century Native Americans still do not have the access to and quality of health care to which they are entitled.

As my colleague from North Dakota has so poignantly illustrated time and time again, there is a health care crisis in Indian country. Native Americans are 200 percent more likely to die from diabetes, 500 percent more likely to die from tuberculosis, 550 percent more likely to die from alcoholism, and 150 percent more likely to die from accidents. Suicide is the second-leading cause of death for Native American adolescents, 2½ times the national average. Native Americans have a life expectancy nearly 6 years less than the rest of the U.S. population.

That is unacceptable. And it is why it is so important that we pass the reauthorization of the Indian Health Care Improvement Act.

More than 1.8 million Native Americans and Alaska Natives rely on the Indian Health Service for health care. Since the act was first authorized in 1976, the ways in which health care is delivered in this country have changed enormously. The bill before us helps meet the contemporary needs of Indian country.

I believe that the inability of many Indian people to receive preventive and nonemergency care is one of the reasons why there are such significant health disparities that exist between Native Americans and the rest of the U.S. population. In North Dakota, when the IHS clinic closes at 5 p.m. on the weekdays and is closed on the weekends, many go without care. I am pleased the bill before us addresses this challenge by establishing grants for demonstration projects including a convenient care services program to expand the availability of health care. It also has a renewed emphasis on disease prevention and health promotion.

The bill also takes important steps to provide training and incentives to increase the number of health care professionals in Indian country, especially Native health care professionals who understand the unique conditions facing their own communities and can provide care with greater cultural awareness. At the University of North Dakota, three programs authorized by the Indian Health Care Improvement Act—the Quentin N. Burdick Indians Into Medicine, Indians Into Nursing, and Indians Into Psychology Programs—are recruiting increasing numbers of Native Americans into medical professional programs. Graduates of these programs are making a real difference throughout Indian country, and I am pleased these successful programs are continued in the bill.

It also includes much needed provisions to address the youth suicide crisis that exists throughout Indian country by authorizing grants to deliver more counseling and suicide prevention services to tribal communities.

Finally, I am pleased my amendment to increase the use of video service delivery to assist in the outreach and enrollment of individual Indians in Medicare and Medicaid was incorporated into the managers' amendment. Remote video access to government services has all the benefits of face-to-face communication, without the costs and difficulties associated with traveling long distances from rural and remote reservations. To date, video service delivery has allowed for more than 300 completed applications for benefits, more than double what would be expected through conventional delivery methods. My amendment will allow for the expansion of this successful effort to other reservations across the country.

We have been working on reauthorization of the Indian Health Care Improvement Act for a number of years. I think Native Americans have waited long enough and it is time we deliver them this bill which begins to reverse the disparate health disparities that exist.

I do not expect that we will be able to solve all of the health care challenges that exist in Indian country with this one bill, but I expect that we will be able to make substantial progress in addressing some of the most pressing needs and creating a stronger system for the future.

Again, I want to recognize the extraordinary work of Senator DORGAN in delivering a truly bipartisan bill that meets the urgent health care needs of Native Americans in North Dakota and across the country. I urge my colleagues to support this bill.

Mr. LEVIN. Mr. President, today the Senate will pass the Indian Health Care Improvement Act of 2008. This bill would reauthorize and modernize the Indian Health Care Improvement Act which funds and authorizes health care services and programs to Native American Indians and Alaska Natives and reaffirms our commitment to ensuring that we meet our treaty and legal obligation to provide these communities with access to quality health care.

Reauthorizing the Indian Health Care Improvement Act has been long overdue. The last time the Congress reauthorized the Indian Health Care Improvement Act was in 1992, and this act has been up for reauthorization since 2001. The Indian Health Service has not been updated for far too long. As health care evolves and improves programs must be modernized to reflect new advances in the health care system. The Indian Health Care Improvement Act has not been modernized since 1992, 16 years ago, and is falling behind. We have a trust responsibility to provide health care to Native American Indians and Alaska Natives. We have not met that responsibility.

The disparities that exist between Indian communities and other Americans are overwhelming. The life expectancy for Indians is almost 6 years less than the rest of this country's population and the suicide rate is 2.5 times higher than the national average. Death due to alcoholism or tuberculosis is more than 600 percent more likely; and, Indians are 318 percent more likely to die from diabetes. These statistics are unacceptable and we need to continue to ensure that we close the gap.

The passage of this bill brings us one step closer to ensuring that the Indian Health Service is adequately funded and that programs to address the health care needs of these communities are available.

Mr. FEINGOLD. Mr. President, I am pleased to support final passage of the Indian Health Care Improvement Act Amendments of 2007. This bill is long overdue, and I hope that House works expediently to move this bill forward so that we can get this bill to the President and signed into law.

Throughout the Senate's work on this bill, I have been impressed with the bipartisan work that Senator DORGAN and the Senate Indian Affairs Committee have put into moving this bill forward. It was not any easy process, but I commend the committee for its ongoing dedication to significant consultation with Indian Country in drafting this bill and seeing it through to completion.

There are significant unmet needs in Indian Country throughout this Nation, and addressing the unmet health care needs ranks as one of the most significant problems that we must address. The Federal Government has a longstanding and well-established trust responsibility with regard to American Indian affairs, and this trust responsibility extends to providing good health care to communities throughout Indian Country.

For too long, the Federal Government has not lived up to its Federal trust responsibility commitments, but I hope that passage of this legislation will set the Federal Government on a course toward better supporting the needs of our American Indian communities, whether they be health care, education, or housing needs. While this bill is a vital step in the right direction, we need to follow through with fiscally responsible increased funding for the important programs authorized in this legislation.

This bill has the support of tribal governments throughout the United States, including the 11 tribes in my State of Wisconsin. I have heard from a number of constituents in Wisconsin about the need to pass this bill this year. The improvements that the legislation will make to various Indian Health Service programs including clinical programs on the various reservations throughout the State and urban Indian programs in Milwaukee and Green Bay are significant, and it is my hope that this bill will help improve the quality of health care provided to American Indians living throughout Wisconsin.

Health care is consistently the No. 1 issue that I hear about all over my home State of Wisconsin. When I hold my annual townhall meetings across the State, many people come to tell me about problems with our overall health care system, and data shows us that these problems are often most acutely felt in Indian Country. Lack of access to good health care is a problem that disproportionately affects American Indians throughout the United States. According to recent studies, American Indians and Alaska Natives are 200 percent more likely to die from diabetes, more than 500 percent more likely to die from alcoholism, and approximately 500 percent more likely to die from tuberculosis.

Some may doubt whether this legislation is needed or whether it will really help improve the lives of Americans. The staggering statistics that highlight the health care disparities faced by American Indians show just how imperative it is that we pass this legislation, which is long overdue. These statistics also help illustrate the vast

amount of work that remains to be done to improve the quality of health care in American Indian communities beyond passage of this legislation. Nevertheless, this bill takes an important first step toward addressing these health care disparities through the many reforms it makes to Indian health care programs. For example, modernizing Indian Health Services programs through this legislation will help to address the diabetes and suicide crises that exist on reservations—just two examples of the many health care issues that impact the daily lives of American Indians across the country.

Reauthorization of this bill will help encourage health care providers to practice at facilities in Indian Country and encourage American Indians to enter the health care profession and serve their communities. Recruiting talented and dedicated professionals to serve in IHS facilities, whether urban or rural, is a key challenge facing many tribal communities in Wisconsin and around the country. I hope these provisions will help bring additional dedicated doctors, nurses, and other health care professionals to our tribal populations.

This bill also reauthorizes programs that assist urban Indian organizations with providing health care to American Indians living in urban centers around the country. The Urban Indian Health Program represents a tiny fraction of the Indian Health Services budget, but the small amount of resources given to the urban programs provides critical health services to those Indians living in urban areas. Contrary to what some people may think, the majority of American Indians now live in urban areas around the country, including two urban areas in my State—Milwaukee and Green Bay. Throughout our Nation's history, some American Indians came to urban centers voluntarily, but many were forcibly sent to urban areas as a result of wrongheaded Federal Indian policy in the 1950s and 1960s and have since stayed in urban areas and planted roots in these communities.

As a result of this movement to urban centers, Congress created the urban Indian program in the late 1970s to address the growing urban Indian population around the country. The Federal Government's responsibility to American Indians does not end simply because some American Indians left their ancestral lands and moved to urban locations—particularly when some of them had little choice in the matter.

While this legislation takes important steps toward improving urban Indian health care programs, we need to do much more to support these urban programs, including fighting for increased appropriations. I have been disappointed that the President has proposed zeroing out the urban Indian program in past budgets, and unfortunately, the President's budget request for fiscal year 2009 is no different. As in years past, I have joined with my colleagues to urge the Senate to restore funding for urban Indian programs to the Federal budget for fiscal year 2009, and I hope this year the Senate can also provide a much-needed boost in funding for the urban Indian programs.

I voted for an amendment offered by Senators SMITH and CANTWELL that would permit, but not require, the Secretary of HHS to create an area distribution fund to allocate funding resources for IHS facilities construction to all 12 of the IHS service areas. I have heard a lot of concern from tribes in my State of Wisconsin about the way that construction facility funds are allocated and the fact that certain IHS service areas, including the Bemidji region covering Wisconsin, do not fare well under the current system. I recognize that there needs to be an overall boost in the appropriations for IHS facilities construction to help tribes currently on the construction priority list as well as those tribes that cannot even get on the current list, and I look forward to supporting fiscally responsible efforts to boost funding for various IHS programs, including this one. But in the meantime, we should explore opportunities to address innovative solutions to this problem, and this amendment takes a reasonable approach to addressing this problem. Any efforts to create an area distribution fund should involve significant consultation with tribes throughout Indian Country, and I am pleased this amendment makes clear that such consultation would be required.

I also voted for amendment 4032, offered by the Senator from Oklahoma, because it is critically important that sexual assault victims be able to find out whether they have been exposed to HIV. However, I am concerned about the way that the amendment was drafted. If there is a conference on this bill, I would urge conferees to consider making this provision consistent with the existing provision governing the testing of defendants in Federal cases, 42 U.S.C. section 14011, or at a minimum to clarify how it would relate to that law. I also would urge them to ensure that the new provision complies fully with the requirements of the fourth amendment.

Mr. President, Indian Country has made many compromises in order to move this bill forward, and passage of this bill is long overdue. The Senate's actions today mark an enormous victory for Indian Country, and I hope that the House will quickly take this bill up so that we can get this bill signed into law by the President this year.

This bill takes concrete and positive steps toward addressing some of the health care needs facing American Indian communities around the country, and I look forward to working with my colleagues to build on this legislation in the coming months and years. Challenges facing American Indians throughout the United States extend beyond health care issues into issues of improving economic development, educational opportunities, and affordable and safe housing opportunities, and I hope we can continue to work together in a bipartisan way to pass other important measures this year. Together, tribal nations throughout all our States can work closely with the Federal Government to address the vast array of these unmet needs. Passage of the Indian Health Care Improvement Act Amendments of 2007 today provides an important foundation going forward, and it is up to all of us to see that this foundation is strengthened in the coming months and years.

Mr. DORGAN. Mr. President, I wish to take a few minutes to talk about the vote we had earlier today on an amendment offered by Senator VITTER to the Indian Health Care Improvement Act. Senator VITTER described his amendment, which was adopted by the Senate, as codifying a longstanding policy that prohibits Federal funds from being used to pay for abortions.

I agree that Federal funding should not be used to pay for abortions. I have always supported the existing funding prohibition known as the Hyde amendment that has been added in the appropriations process every year since 1976.

That being said, I opposed Senator VITTER's amendment because the amendment would only codify the Hyde amendment with respect to the Indian Health Service. I think we should apply the same standard to all Federal health programs and not set up a separate standard that only applies in Indian Country.

Mr. DORGAN. Mr. President, the next vote will be a vote on final passage. I will take just 30 seconds.

I do want to say that Senator MURKOWSKI has helped get us to this point in a very significant way. As to Senators BAUCUS, GRASSLEY, KENNEDY, ENZI, KYL—and especially Senator REID, who allowed us to spend time on the floor on this bill—and the 31 cosponsors of the legislation, I thank all of them.

I thank Allison Binney, the majority staff director, and David Mullon, the minority staff director, and the really talented group of staff members who worked very hard on this legislation. I say a hearty thank-you to them.

Mr. President, I ask unanimous consent that a list of all their names be printed in the RECORD.

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

Indian Affairs (Democratic staff)

Allison Binney (Staff Director), Ted Charlton, Cindy Darcy, Heidi Frechette, John Harte, Tracy Hartzler-Toon, David Holland, Jerci Powell (intern), Eamon Walsh, Rollie Wilson.

Indian Affairs (Republican staff)

David Mullon (Staff Director), Megan Alvanna-Stimpfle, Jim Hall, Rhonda Harjo, Gerald Moses, Jonathan Murphy.

Finance Committee (Senator Baucus' staff)

Catherine Dratz, Michelle Easton, Deidre Henry-Spires, Richard Litsey, David Schwartz, Russ Sullivan.

Finance Committee (Senator Grassley's staff)

Becky Schipp, Rodney Whitlock.

Democratic Policy Committee (DPC)

Kory Caro, Liz Engel, Ryan Mulvenon.

HELP Committee (Senator Kennedy's staff)

David Bowen, Caya Lewis, Lauren McFarran, Peter Romer-Friedman, Tanchia Terry, Portia Wu.

HELP Committee Staff (Senator Enzi's staff)

Greg Dean, Shana Christup, Katherine McGuire, Randy Reid (Senator Enzi's Legislative Director), Amy Shank.

Senator Reid's Leadership staff

Carolyn Gluck, Kate Leone, Darrel Thompson, Marcela Zamora.

Senator Kyl's staff

Jennifer Romans.

Mr. DORGAN. It has been 8 years now that we should have advanced this legislation to improve Indian health care, and after 8 long years we finally have it done—at least through the Senate after this final passage vote. I say thanks to all of my colleagues for their patience and also their help.

I yield the floor to Senator MURKOWSKI.

The ACTING PRESIDENT pro tempore. The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, I, too, want to thank so many who have done so much to advance this legislation. Very rarely do we see an opportunity for Indian bills of any nature to receive floor time, so I want to thank all our colleagues to be able to debate this very important issue with them.

I thank especially Chairman DORGAN for his leadership on this legislation. He has mentioned so many who have participated throughout the years, including the staffs, but we also need to recognize the leadership of the former chairman, Senator Ben Nighthorse Campbell, and, of course, Senator MCCAIN, Senator DORGAN, Senator INOUYE—so many who have done so much.

I also want to acknowledge the National Tribal Steering Committee for their efforts—great tribal leaders coming together to advance this very important legislation.

I have a long list of thank-yous, but truly it has been a great effort, and we appreciate the leadership on both sides in advancing this legislation.

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

Mr. REID. Mr. President, the one thing both of these Senators did not mention is the wonderful work they have done. The chairman and ranking member of the Indian Affairs Committee were able to reach out to Members on both sides of the aisle. This is truly a bipartisan piece of legislation. Is it everything we wanted? Is it everything they wanted? No. But it is a good piece of legislation. For the Indians around America today, it is a really bright day. So I appreciate the good work of Senators DORGAN and MURKOWSKI, who have done very good work.

Mr. President, I am happy to yield to my friend.

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

Mr. MCCONNELL. Mr. President, let me add my congratulations to Senator DORGAN and particularly Senator MURKOWSKI for their excellent work in putting together this very important piece of legislation. I commend them both for outstanding work.

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

ORDER OF PROCEDURE

Mr. REID. Mr. President, I ask unanimous consent that notwithstanding the previous order, the Senate recess from 12:30 to 2:25 p.m. for the weekly caucus lunches; that at 2:25 p.m. the Senate begin the 20 minutes of debate prior to a vote on the motion to invoke cloture on the motion to proceed to S. 2633 as provided under the previous order, with all other provisions of the previous order remaining in effect; further, that if cloture is not invoked, the next rollcall vote on the motion to invoke cloture on the motion to proceed to S. 2634 occur at 4 p.m, with the Senate in a period of morning business until 4 p.m., with the time equally divided and Senators permitted to speak up to 10 minutes each.

So, Mr. President, because of problems that sometimes come here with scheduling, we are going to bifurcate, but it will only be for about 50 minutes. We will have about 50 minutes of morning business until the vote at 4 o'clock. I appreciate everyone's cooperation.

The ACTING PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

Under the previous order, the Dorgan substitute amendment, as amended, is agreed to.

The amendment (No. 3899), as amended, was agreed to.

The ACTING PRESIDENT pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

The ACTING PRESIDENT pro tempore. The bill having been read the third time, the question is, Shall it pass?

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

The ACTING PRESIDENT pro tempore. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from New York (Mrs. CLINTON), the Senator from Connecticut (Mr. DODD), the Senator from Connecticut (Mr. LIEBERMAN), and the Senator from Illinois (Mr. OBAMA) are necessarily absent.

I further announce that, if present and voting, the Senator from Connecticut (Mr. LIEBERMAN) would vote ''yea.''

Mr. KYL. The following Senators are necessarily absent: the Senator from Texas (Mr. CORNYN), the Senator from Arizona (Mr. MCCAIN), and the Senator from Virginia (Mr. WARNER).

Further, if present and voting, the Senator from Texas (Mr. CORNYN) would have voted ''yea.''

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 83, nays 10, as follows:

[Rollcall Vote No. 32 Leg.]

YEAS—83

Akaka	Dorgan	Menendez
Alexander	Durbin	Mikulski
Barrasso	Ensign	Murkowski
Baucus	Enzi	Murray
Bayh	Feingold	Nelson (FL)
Bennett	Feinstein	Nelson (NE)
Biden	Grassley	Pryor
Bingaman	Hagel	Reed
Bond	Harkin	Reid
Boxer	Hatch	Roberts
Brown	Hutchison	Rockefeller
Brownback	Inouye	Salazar
Bunning	Isakson	Sanders
Burr	Johnson	Schumer
Byrd	Kennedy	Shelby
Cantwell	Kerry	Smith
Cardin	Klobuchar	Snowe
Carper	Kohl	Specter
Casey	Kyl	Stabenow
Chambliss	Landrieu	Stevens
Cochran	Lautenberg	Tester
Coleman	Leahy	Thune
Collins	Levin	Voinovich
Conrad	Lincoln	Webb
Craig	Lugar	Whitehouse
Crapo	Martinez	Wicker
Dole	McCaskill	Wyden
Domenici	McConnell	

NAYS—10

Allard	Graham	Sununu
Coburn	Gregg	Vitter
Corker	Inhofe	
DeMint	Sessions	

NOT VOTING—7

Clinton	Lieberman	Warner
Cornyn	McCain	
Dodd	Obama	

The bill (S. 1200), as amended, was passed.

(The bill will be printed in a future edition of the RECORD.)

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

The motion to lay on the table was agreed to.

Mr. REID. Mr. President, the Senate has taken an important step today by passing S. 1200, the Indian Health Care Improvement Act Amendments of 2007.

I am now pleased to join the other 30 cosponsors of this legislation in sending it to the House for their consideration.

When signed into law, this legislation will:

increase and improve recruitment and retention programs for Indian health professionals;

improve communicable and infectious disease monitoring and provide for more research on issues unique to those living on reservations;

improve and expand diabetes screening and treatment programs;

expand programs to prevent domestic violence, sexual abuse, and substance abuse, in Native American communities;

incorporate and encourage the use of technology in delivering health care services and

providing treatment, which is so important to our rural Indian communities;

and encourage States to increase outreach to Indians to help them to enroll in Medicaid and SCHIP programs.

This legislation is supported by a broad, bipartisan coalition, those in Indian Country, and many organizations that advocate for eliminating disparities in health care.

I would like to take this opportunity to acknowledge the support and leadership of particular Senators and their staffs.

The bill managers have been strong and articulate advocates for the bill, and shown great flexibility.

I commend Senator DORGAN and his staff, particularly Allison Binney, Cindy Darcy, Heidi Frechette and Ben Klein.

I commend Senator MURKOWSKI and her staff, including David Mullon and Nathan Bergerbest.

I commend Senator BAUCUS, and his staff, particularly David Schwartz and Richard Litsey; and Senator GRASSLEY and his staff, including Rodney Whitlock, who have insisted on improvements in the administration of Indian health programs.

I commend Senator KENNEDY and his staff, particularly Caya Lewis, and Senator MIKE ENZI and his staff, including Randi Reid, Shana Christrup, Greg Dean and Amy Shank, who helped us negotiate many difficult issues.

On my staff and part of the Democratic leadership team, I commend Kate Leone, Carolyn Gluck; Kory Vargas Caro, Elizabeth Engel, and Ryan Mulvenon.

I want to say a special word of thanks to Tracy Hartzler-Toon, who has worked tirelessly for over a year to help make today possible.

She has served me, the Indian Affairs Committee, and the Senate very well. And most importantly, she has served the residents of Indian Country exceedingly well.

I also thank my colleagues, the Republican leader, Senator MCCONNELL, and his health policy advisor, Megan Hauck, and Senator JON KYL, and particularly Jennifer Romans, for their agreement and commitment to see that this bill finally received its due consideration.

Lastly, I want to acknowledge the support of the late Senator Craig Thomas of Wyoming. Before he passed away last year, his leadership on the Indian Affairs Committee was helpful in bringing the Senate to this moment.

With the help of so many, both in the Capitol and around the country, we have taken an important step toward providing Indian Country some of the health care services that many in the rest of this Nation have enjoyed for years.

I urge the House to take quick action on H.R. 1328, the companion bill to what we passed today, so we can get this important legislation to the President's desk and make these services a reality.

The ACTING PRESIDENT pro tempore. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I wish to say a few words about this vote, and then I am going to ask unanimous consent that Senator MURKOWSKI be recognized, then Senator ENZI, Senator FEINGOLD, and Senator BOXER. I believe Senator ENZI is going to ask for 10 minutes, Senator FEINGOLD 20 minutes, and Senator BOXER 15 minutes. I ask by unanimous consent that be the order.

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

Mr. DORGAN. Mr. President, I will take a couple of additional minutes to say how pleased and proud I am that we have passed by a very wide margin the first improvement in Indian health care since 1992. These, after all, are the first Americans. They were here first. We signed treaties with them, we took their land, we put them on reservations, made promises, and we have a trust responsibility. We said ''we promise.'' The fact is, we have not kept those promises for a long time, especially with respect to Indian health care.

Finally, at long last, this Congress—and thanks to Senator REID and all the folks who allowed this to be on the floor of the Senate for the time that it was—we finally have made some progress, the first time since 1992 that we have reauthorized the Indian Health Care Improvement Act. This is a big deal. This will save lives. We have more steps to take. The House has a bill with which it has to deal. It will, and we will be in conference, and finally we will be able to have a bill before the President of the United States for his signature in this year.

I have spoken at length. I know people are tired of hearing me. The Presiding Officer is from Montana. He and I held a hearing on the Crow Indian Reservation in Montana. We heard an earful about Indian health. I have held listening sessions around the country in different States with Indian tribes. I cannot tell you the number of stories I have heard that had me going away from these meetings shaking my head wondering: What on Earth can we do to fix this situation? How much will it take for us to fix this situation?

I recall a grandmother on the Crow Reservation, MT, standing up with a beautiful picture of her 5-year-old granddaughter who had died. After essentially a rather lengthy story, she asked: How do you justify this, a young girl spending the last 3 months of her life in unmedicated pain because the health care system does not work for that young girl? The stories go on and on.

I am convinced we must do better, and I am determined and it was my priority when I became chairman of this committee to finish this job. I know Ben Nighthorse Campbell worked hard on it, and Senator MCCAIN, when he was chairman of the committee, worked hard on it. Finally, Senator MURKOWSKI and I made it a priority for this committee to say: We have to fix this situation. This is not some option. The promise of health care means if we do not keep this promise, people will die. I have named some of those people, some of them children.

We have to do better. And this vote today, a very significant vote in the Senate, an overwhelming vote, 90 percent of the Senate saying we agree, let's fix it, that is something I think is going to be unbelievably welcome news to American Indians all across this country today. It has been a long time coming, 16 years, but finally—finally—we made progress, and I believe this progress will save lives.

Mr. President, I thank Senator MURKOWSKI who has been an enormous partner in trying to get this bill completed. As I close, I will mention our staff director, Allison Binney, also Ted Charlton, Cindy Darcy, Heidi Frechette, John Harte, Tracy Hartzler-Toon, David Holland, Jerci Powell, Eamon Walsh, and Rollie Wilson on our side; and David Mullon, staff director on the minority side, Megan Alvanna-Stimpfle, Jim Hall, Rhonda Harjo, Gerald Moses, Jonathan Murphy, and so many others.

Those people I have named have worked a lot. They worked behind the scenes, long hours, late at night, and on weekends to help make this possible. I say a heartfelt thanks to them for their wonderful work.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, I rise to recognize the passage of the Indian Health Care Improvement Act. I again thank the majority leader and minority leader for committing floor time for this bill. Rarely have Indian bills received time on the Senate floor, but this is one that is very important to the well-being of our country's Native people that the attention it has been given by the Senate is more than justified.

I thank my colleagues for their commitment in considering this legislation, addressing the issues, and supporting our efforts to improve health care services for American Indians and Alaska Natives.

As with many bills, the provisions fall under more than one committee's jurisdiction. The Committee on Indian Affairs, on which I serve as the vice chairman, has shared this bill with the Finance and HELP Committees, and both of these committees have worked in earnest to assist us in crafting a bill to carry the Indian health care system into the 21st century.

I am fortunate to have a chairman on the Indian Affairs Committee—Senator DORGAN—with whom I share a close working relationship. We both have significant populations of Native people in our States with similar issues and challenges in many areas such as health care, education, housing, economic development and transportation.

We have had numerous opportunities to work together in our committee, particularly on youth suicide prevention and treatment and telemedicine. I truly appreciate his persistence and dedication in advancing this bill.

Senators GRASSLEY and BAUCUS have also worked with us closely to advance this measure through the Finance Committee last year which reported the bill out favorably in both the 109th and 110th Congresses. I also wish to recognize their staff Rodney Whitlock, Becky Shipp, and David Schwartz, who worked so closely with the Indian Affairs staff on this bill.

Likewise, Senator ENZI, in his capacity as chairman and now as ranking member of the HELP committee—worked very diligently on this legislation to refine key pieces of the legislation during the 109th Congress and again this year. Greg Dean, Shana Christrup, Randi Reid and Amy Shank devoted countless hours of work with the Indian Affairs Committee to work out issues, which I appreciate. I especially appreciate the leadership and commitment of Senator KYL. He has one of the largest Indian populations in his State. His commitment to Indian issues was reflected by his continued involvement and that of his staff, Jennifer Romans, in working out issues to advance this bill.

We must not forget that this bill reflects the work of our dear colleague and my predecessor, the late Senator Craig Thomas, who held the reins as vice chairman last year. He eagerly pursued efforts to improve health care services for all American Indian communities, including those in his home State of Wyoming on the Wind River Indian Reservation, and it is most fitting that we will honor his work with the passage of this bill. I pointed out on the floor yesterday, in the 109th Congress, Senator MCCAIN made a great effort to reauthorize the act in his role as chairman of the Indian Affairs Committee. Before that, Senator Campbell, who also served as chairman of the Indian Affairs Committee, carried this legislation since the 106th Congress as the original sponsor, along with Senator INOUYE, until Senator Campbell's retirement in 2004.

Between Chairmen Campbell and MCCAIN in the 108th and 109th Congresses, there were 8 hearings on the reauthorization, including joint hearings with the HELP Committee and with the House Resources Committee.

Our efforts had also great help from my good friends Senators STEVENS, DOMENICI, SMITH, COCHRAN, HATCH, and THUNE. These Senators have been longtime friends of our country's Native people, and I want to acknowledge their dedication in promoting American Indian and Alaska Native health.

The Republican staff of the Senate Committee on Indian Affairs has waited a long time for this day to come. David Mullon, the Republican staff director and chief counsel, and Rhonda Harjo, the deputy chief counsel, came to the committee during Senator Ben Nighthorse Campbell's tenure.

Rhonda Harjo has been the lead Republican staff member of the committee for Indian Health Care Improvement Act reauthorization since 2003. Indian country takes pride in her devotion to the betterment of her Native people and I share that pride today.

I also wish to acknowledge the efforts of Jim Hall and Jon Murphy and two Alaskans who recently joined the committee—Gerald Moses and Megan Alvanna-Stimpfle—in preparing this bill for floor consideration.

I also acknowledge the tireless efforts over the past 8 years of the Indian tribal and health care leaders and advocates across the U.S. in helping develop the legislative proposal which served as the basis for this bill. In particular, the National Tribal Steering Committee, consisting of tribal leaders and Indian health representatives, brought together the diverse interests of over 560 tribes across the country to a consensus on this very important measure.

That is no small task and it was handled dutifully by the cochairs of the National Tribal Steering Committee, Chairman Buford Rolin of the Poarch Band of Creek Indians in Atmore, Alabama, Rachel Joseph, former Chairwoman of the Lone Pine Paiute-Shoshone Tribe, in Lone Pine, California, and staff, Kitty Marx from the National Indian Health Board.

Three key Alaska Native leaders played significant roles on the National Tribal Steering Committee: Sally Smith, the chairman of the National Indian Health Board and the Bristol Bay Area Health Corporation; Don Kashevaroff, the president of the Seldovia Village Tribe and chair of the Tribal Self-Governance Advisory Committee; and Valerie Davidson from the Alaska Native Tribal Health Consortium. I appreciate their leadership and thoughtful consideration in the development of this legislation.

A lot of good work went into this bill and our efforts should not go in vain. I look forward to working with my House colleagues and getting this bill on to the President's desk for signature.

Mr. President, we had a brief opportunity to express our thanks to those who have worked so hard on the reauthorization of the Indian Health Care Improvement Act. Again, my sincere thanks and gratitude to Chairman DORGAN for all that he has done.

This is a good day for Indian country, for Alaska Natives who are just waking up back home right now. They are going to wake up to news that they have been waiting to hear for a good decade: that finally we have advanced the Indian Health Care Improvement Act. We have taken that step. We recognize this is not the end-all and be-all in terms of providing for the health care needs of American Indians and Alaska Natives. We know we need to do more, and we are challenged to do that.

We talked about the funding issue and how we must make that next step to make sure it is not just what we put in the authorization, but we back that up with the dollars for the programs.

We have a long way to go, but I think we have made a very significant step today. I am proud of the work of my colleagues today and those who came before us on this very important issue.

''EXXON VALDEZ'' OILSPILL

Mr. President, I wish to take a few minutes this morning to talk about tomorrow because tomorrow the United States Supreme Court will hear the appeal of the ongoing litigation between ExxonMobil and commercial fishermen and other plaintiffs whose livelihoods were negatively impacted, devastated, in fact, by the 1989 *Exxon Valdez* oilspill. The *Exxon Valdez* ran aground on Bligh Reef at 12:04 a.m. on March 24, 1989. It spilled 11 million gallons of oil—this is about the same size as 125 Olympic-sized swimming pools—directly into Prince William Sound in Alaska. The oil from the spill migrated several hundred miles from Bligh Reef and polluted roughly 1,300 miles of Alaskan shoreline. There were 11,000 square miles of ocean that were ultimately affected by this spill, which is believed to be the worst oilspill worldwide with respect to environmental damage.

Regrettably, the spill area is still affected some 19 years later. In 2001, the National Oceanic and Atmospheric Administration studied the shoreline of Prince William Sound for any remaining effects of the spill. Scientists reviewed 91 sites within Prince William Sound and found that 58 percent of these locations were still polluted by oil. Again, this is 19 years after the fact. Some estimates note that beaches and streams in this area are still polluted with over 25,000 gallons of oil.

Of course, the fisheries in Prince William Sound were affected. The herring fishery in this area experienced a dramatic decrease in the years immediately after the 1989 spill. As of 2007, the herring fishery had not improved to the pre-1989 levels. Another example is what has happened with the value of the fisheries permits in this part of the State. In 1988, a fishing permit in Prince William Sound was worth $400,000. As of 2004, the value of each such permit was less than $70,000, a drop of more than 82 percent.

There was a class action jury trial held in Federal court in Anchorage, AK, in 1994. The plaintiffs at that time included over 30,000 commercial fishermen, among those whose livelihoods were gravely affected by the disaster. The jury awarded $5 billion in punitive damages to the plaintiffs. This punitive damage award has been on repeated appeal by ExxonMobil since that time. On December 22, 2006, the Ninth Circuit Court of Appeals reduced the punitive damage award to $2.5 billion. In early 2007, ExxonMobil petitioned the Ninth Circuit for a rehearing en banc. Within a few months, the Ninth Circuit denied

this petition and ExxonMobil appealed to the Supreme Court. Unfortunately, in this intervening time period, with years and years of litigation bringing delay in resolution, we have had several thousand plaintiffs pass away since this litigation began.

Due to the limitations in admiralty law with respect to the recovery of compensatory damages, many Exxon Valdez plaintiffs were not able to recover the financial losses they sustained in the aftermath of this spill. So the punitive damages that are under consideration by the Supreme Court will provide them that level of compensation.

Once the Supreme Court decided to hear this case, I joined with Senator STEVENS and Representative YOUNG in submitting an Alaska congressional delegation amicus brief to the U.S. Supreme Court. In that brief, we argue that the award of punitive damages in this case of reckless and wanton conduct by Exxon not only is permissible under the Clean Water Act, but it is supported by Federal maritime law. Only punitive damages will provide those who were harmed—and who continue to be harmed—with the justice and the fair compensation they deserve.

This litigation needs to end. Nineteen years is far too long for these plaintiffs to wait to be compensated for their loss of income. I am hopeful that the Supreme Court will rule in favor of the plaintiffs in this case, and I, along with so many Alaskans, look for a final resolution to this great tragedy that occurred to us as a State some 19 years ago.

Mr. President, I yield the floor.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will be a period of morning business until 12:30 p.m., with the time equally divided and controlled between the two leaders or their designees.

The ACTING PRESIDENT pro tempore. Under the previous order of the Senate, the Senator from Wyoming is recognized for 10 minutes.

EQUALIZING THE TAX TREATMENT OF HEALTH INSURANCE

Mr. ENZI. Mr. President, I wish to congratulate the Senator from North Dakota, Mr. DORGAN, and the Senator from Alaska, Ms. MURKOWSKI, on the piece of legislation we just passed. It is extremely critical to a number of people in the United States, the Native Americans.

It was an extremely difficult piece of legislation to do because it is such a diverse group of people. There are Native Americans who are living in cities, there are Native Americans living on reservations, and there is even a difference in reservations because there are some that have a lot of land and a few people, and some have a lot of people and very little land. To come up with a one-size-fits-all is not possible. This bill takes care of all of those people wherever they are and under the circumstances they are under, and it does meet the promise that was given. It culminates 15 years of work that should have been done 15 years ago, but because of the diversity, it was extremely difficult to do. And the chairman and the ranking member, working together, were able to pull that together. So I congratulate both of them for their efforts and their capability of working with everybody in this body, with probably about 100 amendments that were thought about, though not all were offered. The solutions, the ways to solve a lot of those problems are included in the bill. I think it is a very good bill, and they deserve a lot of credit for the way they worked on it and the effort they put into it and the result they got. I am looking forward to getting it resolved on both ends of the building and the President signing it, and I congratulate both of them.

I do rise today, however, to talk about finding other solutions to our health care crisis. That is a part of it. We have extended the children's health insurance plan until March of 2009, so that part has been partly solved, but my wife Diana and I travel to different parts of Wyoming most weekends, and the No. 1 issue on people's minds is their health care. They all ask me what I am going to do to make sure they have the health care they need. I am able to tell them a lot of things I am working on, but I am not able to tell them very much about things actually getting accomplished. This troubles me because our constituents deserve our help. It is time for real action, and I hope we are able to do something on health care this year.

As the senior Republican on the Committee on Health, Education, Labor and Pensions, I spend a lot of time working on health care issues. I have spoken to this body many times about a bill that I am working on, that I have been working in conjunction with anybody in this Chamber who is interested in health care, and trying to pull together the idea so that we can do some things in health care, any one of which would help us to get closer to a solution for all Americans.

The bill I have put together is one called Ten Steps to Transform Health Care in America. That will fix many of the common complaints I hear from my constituents. Why ten steps? Well, I have discovered over the course of the years I have been in this Chamber that if you try to put together one massive comprehensive bill that solves everything, you will have one piece that 5 people don't like, another piece 8 people don't like, another 11 people don't like, and another 3 people don't like, until pretty quickly you are at 51 votes and you can't get the bill done. When you try to do something comprehensively, it often looks revolutionary. And we don't do things revolutionarily; we do them evolutionarily. So I put together 10 pieces, any one of which gets us closer to having every American insured. All 10 would get every American insured. So I hope people will take a look at it.

Today, I am just going to focus on one step; that is, the first, and that is equalizing the tax insurance treatment for all Americans, not just the ones who get health insurance at work. I encourage everyone watching to look at my Web site, enzi.senate.gov, to learn more about all the steps of the bill. Again, I emphasize that these are bipartisan ideas people have given me.

Because the chairman of the committee has been so involved in the education portion—and we are making progress on the education portion, having sent several pieces to the President already, and we are going to finish the higher education bill, and we are going to finish No Child Left Behind—I have been given the flexibility to look into this health care area. The chairman and I sat down and worked on principles of health care, and then I have sought to get ideas from both sides of the aisle and incorporated them as much as I can into 10 steps.

Before I go into the details of step 1, I wish to say a few things about the entire proposal.

If the Ten Steps bill were to become law, the end result would be an insurance card for everyone. Now, lots of people have insurance cards—Members of Congress have them, people who work for big companies have them, the kids in Wyoming who participate in the State Children's Health Insurance Program have them. Lots of people have them, and most of those people who have insurance cards are happy with the care they are getting. They do not want change. And the bill doesn't change that. If you have an insurance card now, you can keep that card and keep getting the exact same care you are getting. The problem is the 47 million or so Americans who don't have an insurance card. My bill gives all those people cards. If they can't afford the cards because they are low income, this bill helps them by giving them the money they need to purchase the insurance card. The bottom line is that everyone has a card and everyone will be able to get the care they need.

So how does the bill get everyone an insurance card, and will we bust the budget in the process of getting everyone an insurance card? The bill won't bust the budget. It won't be free, but it won't bust the budget. So how is this possible? Well, in order to understand how the bill works, it is important to review a few facts about the history of health insurance in this country.

Right now, about 60 percent of the folks under age 65 are getting their health insurance through their job. The question is why. Why are 60 percent of Americans getting their health insurance through their job? Well, the short answer to that question is, because of the way employer-sponsored