PROVIDING FOR A CONDITIONAL ADJOURNMENT OF THE HOUSE OF REPRESENTATIVES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H. Con. Res. 279, received from the House.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 279) providing for conditional adjournment of the House of Representatives.

Mr. DORGAN. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the motion to reconsider be laid upon the table, without any intervening action or debate.

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

The concurrent resolution (H. Con. Res. 279) was agreed to.

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007—Continued

The PRESIDING OFFICER. The Senator from Alaska.

Mrs. MURKOWSKI. Mr. President, I wished to echo the comments of my colleague and my chairman on the Indian Affairs Committee. Reauthorization of this Indian Health Care Improvement Act is something that is long overdue. When we sat down as the chairman and vice chairman of this committee to assess the priorities of the committee, it was absolutely clear the one thing we could do now to help make a difference in the lives of American Indians and Alaska Natives was to improve the health care system, the delivery, and the access.

The last time this was updated, if you will, was 1992. Think about what has happened in health care and the technologies and the techniques since 1992. We owe it to our constituents across the country—not just in Alaska, where we have 225 tribes, but from California to Maine, from the Dakotas down to Florida—we owe it to all our constituents to finally see this reauthorization through. We do acknowledge there are some issues that are as yet unresolved, but it is not as if we have not had the time to resolve them. The time is now to make it happen.

I, too, would urge the Senate to work together, as the chairman and I have, in a very cooperative, very bipartisan manner to figure out how we move this legislation through the Senate to the House so it is finally enacted into law.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

AMENDMENT NO. 3900

Mr. SANDERS. Mr. President, I ask unanimous consent that the pending amendment be set aside so I can send an amendment to the desk, and I ask for its immediate consideration.

The PRESIDING OFFICER. Without objection, the clerk will report.

The legislative clerk read as follows:

The Senator from Vermont [Mr. SANDERS], for himself, Mr. OBAMA, Ms. CANTWELL, Mr. KERRY, Ms. SNOWE, Ms. COLLINS, Mr. SUNUNU, Mr. MENENDEZ, Mr. LEAHY, Mrs. CLINTON, and Mr. KENNEDY, proposes an amendment numbered 3900.

Mr. SANDERS. Mr. President, I ask unanimous consent that the amendment be considered as read.

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

The amendment is as follows:

(Purpose: To provide for payments under subsections (a) through (e) of section 2604 of the Low-Income Home Energy Assistance Act of 1981)

At the end of title II, insert the following:

SEC. 2___. LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM.

(a) IN GENERAL.—There are authorized to be appropriated, and there are appropriated, out of any money in the Treasury not otherwise appropriated—

(1) $400,000,000 (to remain available until expended) for making payments under subsections (a) through (d) of section 2604 of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623); and

(2) $400,000,000 (to remain available until expended) for making payments under section 2604(e) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(e)), notwithstanding the designation requirement of section 2602(e) of such Act (42 U.S.C. 8621(e)).

(b) DESIGNATION.—Any amount provided under subsection (a) is designated as an emergency requirement and necessary to meet emergency needs pursuant to subsections (a) and (b) of section 204 of S. Con. Res. 21 (110th Congress), the concurrent resolution on the budget for fiscal year 2008.

Mr. SANDERS. Mr. President, let me begin by saying this amendment is being cosponsored by Senators SNOWE, COLLINS, OBAMA, CANTWELL, SUNUNU, MENENDEZ, STABENOW, CLINTON, LEAHY, and KERRY. This amendment, which would increase LIHEAP funding by $800 million, also has the support of the National Energy Assistance Directors Association, the National Fuel Funds Network, the American Gas Association, the National Association of State Energy Officials, and many other groups.

This amendment is as simple and straightforward as it can be, and what it is about is that at a time when, as everybody knows, home heating prices are going through the roof, it is getting colder every day—it will be below zero in Vermont this week—this amendment would provide real relief to millions of senior citizens on fixed incomes, low-income families with children, and persons with disabilities.

Specifically, this amendment would provide $800 million emergency funding for the Low-Income Home Energy Assistance Program, otherwise known as LIHEAP. Four hundred million dollars of this funding would be distributed under the regular LIHEAP formula and the other $400 million would be used under the contingency LIHEAP program.

Last month, I introduced the Keeping Americans Warm Act to provide $1 billion in emergency LIHEAP funding. I am pleased that this bill has garnered 26 cosponsors—19 Democrats, 6 Republicans, and 1 Independent.

In addition, as you know, on December 3, 38 Senators cosigned a letter spearheaded by Senator JACK REED and SUSAN COLLINS to the Labor-HHS-Education Appropriations Subcommittee Chairman HARKIN and Ranking Member SPECTER urging the appropriations committee to provide a total of $3.4 billion in LIHEAP funding.

As you know, there is a lot of discussion right now in seeing that there be a substantial increase in LIHEAP funding in the economic stimulus bill that is being talked about, which I certainly support.

I would also like to take this opportunity to commend Subcommittee Chairman HARKIN, Ranking Member SPECTER, Appropriations Chairman BYRD, and Ranking Member COCHRAN for providing a total of $2.6 billion in funding for LIHEAP in the Omnibus appropriations bill. I understand how difficult it was to reach a deal on this bill. I appreciate everything Senator BYRD and others have done for LIHEAP to make sure people in our country do not go cold.

Unfortunately, this $2.6 billion in funding for LIHEAP, while an 18-percent increase from last year, is still 23 percent below what was provided for LIHEAP just 2 years ago. And that 23-percent reduction is not even adjusted for inflation. I am talking about nominal dollars.

Two years ago, as I think every American fully understands, the price of heating oil was less than $2.50 a gallon. Today, it is over $3.36 a gallon. In central Vermont, we have seen prices as high as $3.73 a gallon for heating oil. This winter, consumers are projected to pay over $1,800 to heat their homes with heating oil—$1,800 just to stay warm this winter. This winter, it is projected that consumers will be paying over $1,600 to heat their homes with propane. Two years ago, they only paid $1,281.

The skyrocketing prices are already stretching the household budgets of millions of families with children, senior citizens on fixed incomes, and persons with disabilities beyond the breaking point. I cannot tell you—I am sure the situation is not radically different in Pennsylvania—how many people are telling me that when they see these heating bills, they cannot believe it. They just do not know how they are going to stay warm this winter.

Unfortunately, the spike in energy costs is completely eviscerating the purchasing power of this extremely important program in State after State. If Congress does not act soon to confront this problem head-on—and this is a problem which is existing now and will get worse in late January and in February—I fear for the public health and safety of many of our most vulnerable citizens.

The point is, we have to act. We have to act. I support any and all efforts to

expand LIHEAP but, frankly, it will do less good if it is passed in March or in April than it will if it is passed in January and February. We need to get the money out to people now so they do not go cold.

According to the National Energy Assistance Directors Association, due to insufficient funding, the average LIHEAP grant only pays for 18 percent of the total cost of heating a home with heating oil this winter, 21 percent of residential propane costs, 41 percent of natural gas costs, and 43 percent of electricity costs this winter. What this means is that low-income families with kids, senior citizens on fixed incomes, and others will have to make up the remaining cost out of their own pockets. As you know, in this country we are looking at some very rocky economic times. More and more people are unemployed. Poverty is going up. Where are those people going to get these large sums of money to stay warm this winter?

In addition, only 15 percent of eligible LIHEAP recipients currently receive assistance with home heating bills. Eighty-five percent of eligible low-income families with children, senior citizens on fixed incomes, and persons with disabilities do not receive any LIHEAP assistance whatsoever due to a lack of funding. There are many people all over this country who are eligible for this program who are unable to get the help they need. In my own State of Vermont, it has been reported that outrageously high home heating costs, oil costs, are pushing families into homelessness. In fact, it is not uncommon for families with two working parents to receive help from homeless shelters in the State of Vermont because they cannot afford anyplace else to live during the winter.

This is a national energy emergency which is affecting States all over the country, certainly not just Vermont. On January 17, 1 day after the President released $450 million in emergency LIHEAP funding, the National Energy Assistance Directors Association testified in front of the Health, Education, Labor and Pensions Committee chaired by Senator KENNEDY. I very much appreciate his holding that hearing in Boston focusing national attention on this crisis. Here is what the national energy directors reported. This is what they say:

In Arkansas, the number of families receiving LIHEAP assistance is expected to be reduced by up to 20 percent from last year if they are not able to get more funding. Arkansas, 20 percent reduction.

In Arizona, estimates are that they will have to cut the number of families receiving LIHEAP assistance by 10,000 families as compared to last year.

In Delaware, the number of families receiving LIHEAP assistance will be reduced by up to 20 percent. In most instances, your average LIHEAP grant only pays for about 20 percent of the total cost of heating a home in Delaware.

During the winter in Iowa, the regular LIHEAP grant has been cut by 7 percent from last year. The average LIHEAP grant in Iowa is $300. Two years ago, the average grant was $450.

The State of Kentucky can run out of LIHEAP funding as early as next February.

In Maine, the average LIHEAP grant will only pay for about 2 to 3 weeks of home heating costs in most homes in that State, and I can tell you that it stays cold for a lot longer than 2 or 3 weeks in Maine, in New England.

In Massachusetts, the spike in energy costs means that the purchasing costs for LIHEAP has declined by 39 percent since 2006.

The State of Minnesota can run out of LIHEAP funding as early as February.

In New York, many households have already exhausted their entire LIHEAP funding.

While Ohio has seen a 10-percent increase in the number of people applying for LIHEAP assistance, that State will have to cut back its regular LIHEAP grant by between 15 to 20 percent.

Rhode Island, Texas, the State of Washington—on and on it goes. The bottom line is, home heating fuel costs are soaring, and LIHEAP does not have enough money to take care of the needs of people in State after State after State.

In the richest country on the face of the Earth, no family, no child, no senior citizen should be forced to go cold this winter. I am afraid that unless we act, and act very quickly, that is exactly what will be happening.

We hear a lot of talking about energy funding around here. Not every piece of legislation, in fact, is an emergency. This is an emergency. As we speak tonight, people all over this country do not have enough money to stay warm. That situation will only get worse. We have to act, and we have to act now.

Let me again thank the many cosponsors of this legislation. It is certainly bipartisan. There are cold people in Republican States, Democratic States, Independent States. We have to act together, and we have to move as rapidly as we can.

I am offering this amendment now on the Indian health bill. I will offer it at every opportunity I can. I look forward to working with the Members of the Senate to see that we do the right thing so that no American goes cold this winter.

Ms. COLLINS. Mr. President, I wish to discuss funding for the Low Income Home Energy Assistance Program, commonly known as LIHEAP. LIHEAP is a Federal grant program that provides vital funding to help low-income and elderly citizens meet their home energy needs.

Due to record-high oil costs, the situation for our neediest citizens is especially dire this winter. That is why I have sponsored Senator SANDERS' amendment to increase LIHEAP funding by $800 million.

Nationwide, over the last 4 years, the number of households receiving LIHEAP assistance increased by 26 percent from 4.6 million to about 5.8 million, but during this same period, Federal funding increased by only 10 percent. The result is that the average grant declined from $349 to $305. In addition, since August 2007, crude oil prices quickly rose from around $60 a barrel to nearly $100 a barrel earlier this month, so a grant buys less fuel today than it would have just 4 months ago. According to Maine's Office of Energy Independence and Security, the average price of heating oil in our State is $3.30 per gallon, which is $1.09 higher than at this time last year.

This large, rapid increase, combined with less LIHEAP funding available per family, imposes hardship on people who use home heating oil to heat their homes. Low-income families and senior citizens living on limited incomes in Maine and many other States face a crisis situation in staying warm this winter.

The Sanders amendment would provide an additional $800 million as emergency funding for LIHEAP. The term ''emergency'' could not be more accurate. Our Nation is in a heating emergency this winter. Families are being forced to choose among paying for food, housing, prescription drugs, and heat. No family should be forced to suffer through a severe winter without adequate heat.

I urge all my colleagues to support the Sanders proposal to provide vital home energy assistance for the most vulnerable of our citizens.

Mr. SMITH. Mr. President, I rise today to speak in favor of reauthorizing the Indian Health Care Improvement Act, IHCIA, of which I am a cosponsor. Like many of my colleagues, I feel that passing this legislation is long overdue. Since its enactment in 1976, the IHCIA has provided the framework for carrying out our responsibility to provide Native Americans with adequate health care. As we know, the act has not been updated in more than 16 years, despite the growing need among Native Americans.

We cannot allow the health of Native Americans to remain in jeopardy for yet another year. The reauthorization legislation is a major step in addressing the growing health disparities that Native Americans face. The act makes much needed changes to the way the Indian Health Service, IHS, delivers health care to Native Americans and is the product of significant consultation and cooperation with Tribes and health care providers.

I would like to thank Chairman DORGAN and Vice Chair MURKOWSKI for their leadership and for building on the momentum from the last Congress to reauthorize this act.

The IHCIA was last reauthorized in 1992. Now 16 years later, another reauthorization is necessary to modernize Indian health care services and delivery and improve the health status of

Native American people to the highest level possible.

A September 2004 report released by the United States Commission on Civil Rights gives us a snapshot of the health crises Native Americans face. Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 52 percent more likely to die from pneumonia or influenza, and 60 percent more likely to die of suicide.

Also, according to the CDC, American Indians and Alaska Natives, AI/AN, also have the highest rate of suicide in the 15- to 24-year-old age group, and suicide is the second leading cause of death among Native American youth aged 10 to 24. The overall rate of suicide for American Indians and Alaska Natives is 20.2 per 100,000, or approximately double the rate for all other racial groups in the United States. Given these circumstances, the life expectancy for Native Americans is 71 years of age, nearly 5 years less than the rest of the U.S population.

Many serious health issues affect our Native American population. Yet, today, funding levels meet only 60 percent of demand for services each year, which requires IHS, tribal health facilities and organizations, and urban Indian clinics to ration care, resulting in tragic denials of needed services. Reauthorization of the act will facilitate the modernization of the systems, such as prevention and behavioral health programs for the approximately 1.8 million Native Americans who rely upon the system. I sincerely hope that we can pass this legislation and send it to the President for his signature.

Although this bill makes vast and necessary improvements upon current law, it is not perfect. In my home State of Oregon, as well as in many other States across the country, there is concern that the current bill creates inequities among the tribes related to the distribution of health care facilities funding. Senator CANTWELL and I intend to offer an amendment that we are hopeful can resolve this issue because, ultimately we must ensure that all tribes are treated equitably.

The current priority system outlined in S. 1200 seems to favor health facility construction in a few States and will harm Oregon's tribes as well as many others across the country. Since the original bill was drafted, the IHS and tribes have worked together to develop a new and more equitable construction priority system that more fairly allocates funds across Indian Country. This priority system includes the development of an area distribution methodology. This proposed methodology would provide for a portion of facility construction funds to be used to build health facilities that are not part of the current facilities priority system. Unfortunately, the language in S. 1200 does not explicitly account for this agreement made between the tribes and IHS through the National Steering Committee. Many tribes in Oregon and around the country have never received any construction funding and are concerned that the proposed language is outdated and will continue to cause their facilities to lose priority to the extent that it could be 20 to 30 years until facility upgrades would occur.

I offered an amendment during the May 2007 Senate Committee on Indian Affairs markup of S. 1200 that would have allowed for a portion of health facility construction funds to be distributed equitably among all of the IHS areas for local health facilities projects. I withdrew my amendment because Chairman DORGAN assured me that he would work with me to find a suitable compromise before the bill went to the floor. Since then, I have been working with my colleagues and national tribal organizations to develop compromise language. Yet, given all of this effort, some Senators are unwilling to compromise.

Therefore, Senator CANTWELL and I intend to offer our amendment which represents an appropriate middle ground for all tribes. I hope my colleagues will vote in favor of this amendment, and I look forward to continuing to work with them to explore other creative ways to identify approaches that address everyone's interest and ensures that all Native American Indians receive the health care they need and deserve.

I am pleased to see that the bill contains my legislation, the American Indian Veteran Health Care Improvement Act. This legislation would encourage collaborations between the Department of Health and Human Services, HHS, and the Department of Veterans Affairs, VA, resulting in greater access to health care services for American Indian and Alaska Native, veterans of federally recognized tribes. This legislation also would ensure that these AI/AN veterans eligible for VA health care benefits delivered by IHS, an Indian tribe, or tribal organization will not be liable for any out of pocket expenses.

American Indians and Alaska Natives have a long history of exemplary military service to the United States. They have volunteered to serve our country at a higher percentage in all of America's wars and conflicts than any other ethnic group on a per capita basis. As a result, they have a wide range of combat related health care needs. AI/AN veterans may be eligible for health care from the Veterans Health Administration, VHA, or from IHS or both. Despite this dual eligibility, AI/AN veterans report the highest rate of unmet health care needs among veterans and exhibit high rates of disease risk factors.

On February 25, 2003, HHS and the VA entered into a Memorandum of Understanding, MOU, to encourage cooperation and resource sharing between IHS and the VHA. The goal of the MOU is to use the strengths and expertise of both organizations to increase access, deliver quality health care services, and enhance the health status of AI/AN veterans. These collaborations are designed to improve communication between the agencies and tribal governments and to create opportunities to develop strategies for sharing information services and technology. The technology sharing includes the VA's electronic medical record system, bar code medication administration, and telemedicine. Also, the VA and IHS cosponsor continuing medical training for their health care staffs. The MOU encourages VA, tribal, and IHS programs to collaborate in numerous ways at the local level. These services may include referrals for specialty care at a VA facility, prescriptions offered by the VA, and testing not offered by IHS.

At the local level, many partnerships are being formed among IHS, the VA, and tribal governments to identify local needs and develop local solutions. These may include outreach and enrollment for the VA's health system, initial screenings, and other health care services. The anticipated product of these collaborations is to ensure that quality health care is provided to all eligible AI/AN veterans.

In my State, the Portland VA Medical Center and the Portland Area Office-IHS are working on a local MOU for the purpose of improving access to VA health care services for eligible AI/AN veterans. The Warm Springs Confederated Tribes have been instrumental in developing this agreement based on the needs of AI veterans on the Warm Springs Reservation. These veterans often are eligible for health benefits from both the VA and IHS, and it is their intended purpose to make care more seamless, thereby improving access and quality.

In November 2001, President George W. Bush proclaimed National American Indian Heritage Month by celebrating the role of the indigenous peoples of North America in shaping our Nation's history and culture. He said, ''American Indian and Alaska Native cultures have made remarkable contributions to our national identity. Their unique spiritual, artistic, and literary contributions, together with their vibrant customs and celebrations, enliven and enrich our land.''

An important part of the overall contribution of AI/AN peoples to our Nation is the part they play in protecting and preserving our freedoms. Their contributions to our Armed Forces have been made throughout our history. I am hopeful that the VA and IHS will continue to work together to deliver health care services to our Nation's AI/AN veterans that they so deserve. I look forward to hearing about more of these partnership projects, and to learn of their successes.

As I mentioned earlier, Native Americans have some of the highest suicide rates in our Nation. That is why it is so critical that we increase physical and mental health services to this population and, ultimately, that we pass

this bill. I am proud to have cosponsored the telemental health language in this bill. The bill would authorize a demonstration project to use telemental health services for suicide prevention and for the treatment of Indian youth in Indian communities. The Indian Health Service would carry out a 4-year demonstration program under which five tribes, tribal organizations or urban Indian organizations with telehealth capabilities could use telemental health services in youth suicide prevention and treatment.

I also would like to speak to my support of the Urban Indian Health Program, UIHP. It constitutes only 1 percent of IHS's budget; however, 34 UIH centers provide care for nearly 70 percent of the Native American population residing in cities. According to the 2000 Census, nearly 70 percent of Americans identifying themselves as having American Indian or Alaska Native heritage live in urban areas.

In my home State of Oregon, the Native American Rehabilitation Association of the Northwest, NARA, an urban Indian health provider, has been in existence for over 37 years and provides education, physical and mental health services, and substance abuse prevention and treatment that is culturally appropriate to Native Americans and other vulnerable people. NARA is an Indian-owned and operated nonprofit urban Indian health clinic that annually serves over 4,000 people including 257 tribes and bands, of which 25 percent are from Oregon. NARA's health clinic delivers health care services to tribal members from over half of the federally recognized tribes that reside in about 30 States. Notably, NARA is a grant recipient of the Garrett Lee Smith Memorial Act, which it uses to serve Oregon's tribes.

The UIHP has been a fixture of the Indian Health Care Improvement Act since its initial passage in 1976, principally serving urban Indian communities in those cities where the Federal Government relocated Indians during the 1960s and 1970s. Notably, the Federal Government relocated thousands of tribal members to Portland at that time. Although the UIHP overwhelmingly serves citizens of federally recognized tribes, it has the authority to serve other Native Americans, largely those who have descended from the Federal relocatees. S. 1200 provides a modest expansion of authority for the UIHP to engage in a wider array of health related programs, consistent with the many changes that have occurred in health delivery in the United States since the IHCIA was last reauthorized 16 years ago.

Proposals to eliminate or even limit the UIHP within the IHS would have far-reaching and devastating consequences. Urban Indian health clinics report that the elimination of Federal support would result in bankruptcies, lease defaults, elimination of services to tens of thousands of Indians who may not seek care elsewhere, an increase in the health care disparity for American Indians and Alaska Natives, and the near annihilation of a body of medical and cultural knowledge addressing the unique cultural and medical needs of the urban Indian population held almost exclusively by these programs. Notably, Urban Indian health clinics typically leverage IHS funding 2:1 from other sources.

Urban Indian health clinics provide unique and nonduplicable assistance to urban Indians who face extraordinary barriers to accessing mainstream health care. Many Native Americans are reluctant to go to health care providers who are unfamiliar with and insensitive to Native cultures. Urban Indian programs not only enjoy the confidence of their clients but also play a vital role in educating other health care providers in the community to the unique needs and cultural conditions of the urban Indian population. Urban Indian health clinics also save costs and improve medical care by getting urban Indians to seek medical attention earlier; Provide care to the large population of uninsured urban Indians who otherwise might go without care; and reduce costs to other parts of the Indian Health Service system by reducing their patient load.

More than 30 years ago, President Ford saw the great need and had the wisdom to sign into law the Indian Health Care Improvement Act. His signature was a promise made to American Indians that the Federal Government would work to improve their health status. That promise is one that we must not back away from. Reauthorizing this act is a reaffirmation of that commitment and proves that we understand there is work yet to be done to further improve Indian health.

Again, I am thankful to Chairman DORGAN and Vice Chair MURKOWSKI for their leadership and for building on the momentum from the last Congress to reauthorize the act. I hope that we can swiftly resolve any remaining issues and get this long-overdue bill signed into law.

I would like to close my statement with a quote from Mourning Dove, the literary name of Christine Quintasket, a Salish tribal woman from the Pacific Northwest now recognized as the first Native American woman to publish a novel (1888–1936). ''Everything on the earth has a purpose, every disease an herb to cure it, and every person a mission . . . this is the Indian theory of existence.''

There are indeed cures and treatments for the maladies that disproportionately afflict Native Americans: diabetes, alcoholism, and suicide. The purpose and the mission of this bill is to connect those cures with those who need it the most—those who have sought it the longest—and through chapters of our history, have a unique claim to those cures and treatment.

Mr. COCHRAN. Mr. President, I am a cosponsor of the Indian Health Care Improvement Act, which provides updated objectives and policy for addressing the health needs of American Indians.

By virtue of many treaties and agreements, the Federal Government has a trust responsibility—an obligation—to provide a variety of basic needs, including healthcare.

The Indian Health Care Service estimates that it provides about 60 percent of the health care that is needed in Indian Country: an amount that is less than half of what we spend on the health care needs of Federal prisoners. Tribes with the resources, try to make up the difference. In most cases, the result is an absence of health care.

In my State, the Mississippi Band of Choctaw Indians has improved its health care and the overall health of its population over the last 30 years. But the sad fact remains that health care on the reservation is inadequate.

For the 9,600 members of the tribe, there are four doctors. The hospital has 14 beds. The approximately $8 million the tribe spent last year is simply not enough to cover the needs of the Choctaw's growing population.

According to Health Care Financing Review—Summer 2004, Volume 24, Number 4—the national health care expenditure average cost per person per year was calculated at $5,440. Using the $5,440 estimate, the Mississippi Band of Choctaw Indians Health Care System would need over $48 million dollars to cover the tribe's health care costs.

From fiscal year 2000 to fiscal year 2005, there was a 30.4 percent increase in the number of patients from the Mississippi Band of Choctaw Indians who accessed the health care system. During that same time period there was a 41.4 percent increase in the number of ambulatory visits.

According to the CDC, 7 percent of Americans have diabetes. In comparison, 20.5 percent of Choctaws have diabetes, one of the highest percentages of any tribe in the country. From 2000 to 2005 there was a 62.3 percent increase in the number of patients diagnosed with diabetes.

My point in telling the Senate these examples is, with adequate health care, successful preventive care, appropriate facilities, and more health care professionals, lives would be longer and general health would improve.

Statistics for other tribes are similar. Some include alarming incidences of suicide, high infant mortality rates, and practically nonexistent mental health care.

This bill includes provisions that promote better communication between tribes and the Indian Health Care Service, in order to ensure effective administration of the programs meant to assist the well-being of the American Indian population.

I urge my colleagues to vote for the Indian Health Care Improvement Act.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

• Mr. OBAMA. Mr. President, I commend Senator DORGAN and the Committee on Indian Affairs for their leadership on the long-overdue Indian Health Care Improvement Act, IHCIA, Amendments of 2007.

The historical treatment of Native Americans is a tarnished mark on American history. Lawmakers must ensure that this Nation fulfills its treaty obligations to Native Americans and address the injustices that continue to be suffered by the first Americans. I am committed to making sure that Native Americans are treated with respect, dignity, and equality both now and in the future and to ensure that promises made by this great Nation are promises kept as well. As such, I believe it is this country's moral imperative to address the significant health disparities between Native Americans and the American population as a whole.

Diabetes is perhaps the most striking example of such health disparities. American Indians have the highest rate of diabetes in the world. The American Diabetes Association reports that American Indians and Alaska Natives are more than twice as likely to be diagnosed with diabetes as non-Hispanic Whites, and the death rate from diabetes is three times higher among American Indians and Alaska Natives than the rate in the general U.S. population. Yet these statistical averages mask the fact that certain tribal populations are experiencing epidemic rates of diabetes. About half of adult Pima Indians, for example, have diabetes. Even worse, on average, Pima Indians are only 36 years old when they develop diabetes, which contrasts to an average age of 60 years for White diabetics.

Unfortunately, diabetes is not the only health condition that disproportionately affects American Indians. Death rates from heart disease and stroke are respectively 20 and 14 percent greater among American Indians compared to the average U.S. population. We know the infant mortality rate is 150 percent higher for Indian infants than White infants. The rate of suicide for Indians is 2½ times greater than the national rate, and methamphetamine use has ravaged Indian reservations all across the country.

Urban Indians are not exempt from these dire health challenges. In addition to facing higher than average rates of chronic disease and mental health and substance abuse disorders, urban Indians experience serious difficulties accessing needed health care services. Given that over half of the Native American population no longer reside on reservations, our efforts to improve Indian health and health care must include explicit focus on the urban Indian population.

For these reasons, I am proud to be an original cosponsor of the Indian Health Care Improvement Act. Our tribal health care programs must be modernized and prepared to provide preventive and chronic disease health care services and to address other key issues such as access and quality of care concerns. And these activities must be supported while honoring the principle of tribal sovereignty.

The bill before us would enact much needed advancements in the scope and delivery of health care services to Native Americans. In particular, it authorizes a host of new health services, makes crucial organizational improvements, and provides greater funding for facilities construction. Through scholarships, investments in recruitment activities, loan repayment programs, and grants to institutions of higher education, IHCIA also takes steps to help increase the number of Native Americans entering the health services field.

I am especially pleased that the bill addresses well-documented health problems affecting urban Indian communities as well. This proposal provides grants and increased aid for diabetes prevention and treatment, community health programs, behavioral health training, school health education programs, and youth drug abuse programs in urban areas.

I trust my colleagues will agree with me on the critical need to address health disparities facing the Native American community. I urge the Senate to act quickly to pass this bill.•

• Mr. MCCAIN. Mr. President, today the Senate is considering S. 1200, the Indian Health Care Improvement Act, IHCIA, Amendments of 2007. This bill would reauthorize the IHCIA, the statutory framework for the Indian health system, which covers just about every aspect of Native American health care.

I would first like to acknowledge the hard work of Chairman DORGAN and my other colleagues on the Senate Indian Affairs Committee for their efforts to bring this important legislation to the floor. Reauthorization of the IHCIA is critical to the lives of more than 2 million American Indians and Alaska Natives and is long overdue.

The IHCIA expired in 2000, and Indian tribes and health organizations have been working diligently to see it reauthorized. Seven years ago, a steering committee of tribal leaders, with extensive consultation by the Indian Health Service, developed a broad consensus in Indian Country about what needs to be done to improve and update health services for Indian people. During the 109th Congress, we made significant progress towards passing a reauthorization bill. Unfortunately, the Senate was unable to complete work on that bill before adjourning last Congress.

I believe now as I did when I served as chairman of the Senate Indian Affairs Committee during the last Congress that reauthorizing our Indian health care programs is a top priority for us, and I hope that the Senate will move a sound comprehensive bill through the legislative process as quickly as possible. However, there are some key and troubling differences between the bill pending before the Senate and the proposal I put forward at the end of the last Congress, S. 4122. In particular, the new version contains language that would essentially authorize the Indian Health Service to promote ''reproductive health and family planning'' services. As my colleagues know, I have had a longstanding policy against promoting abortion as an acceptable form of birth control, except in cases of rape and incest. I strongly believe that society and government have a legitimate interested in protecting life, born or unborn. Obviously, my thinking on this question applies to the unborn children of patients to the Indian Health Service. I cannot in good conscience support the promotion of abortions at Federally funded IHS facilities or any Federal facilities. I remain hopeful the bill will be modified to allow me to supports its swift passage.

I am, however, supportive of the majority of this bill which builds upon the principles of Indian self-determination. Over the years, Indian health care delivery has greatly expanded and tribes are taking over more health care services on the local level. It is our responsibility to maintain support for these services and promote high standards of quality health care for IHS and its partner units. Among the items provided in this bill are provisions exploring options for long-term care, governing children and senior issues. It also would provide support for recruitment and retention purposes; access to health care, especially for Indian children and low-income Indians. Further, it would provide more flexibility in facility construction programs, consolidated behavioral health programs for more comprehensive care, and would establish a Commission to study and recommend the best means of providing Indian health care.

We must remember that nearly 30 years ago, Congress first enacted the IHCIA to meet the fundamental trust obligation of the United States to ensure that comprehensive health care would be provided to American Indians and Alaska Natives. Yet the health status of Indian people remains much worse than that of other Americans. They have a shorter average lifespan, higher infant mortality rate, and a much higher rate of diabetes than the national average. American Indians and Alaska Natives are 650 percent more likely to die of tuberculosis, 770 percent more likely to die of alcoholism, and 60 percent more likely to die of suicide. The suicide mortality rate among Indian youth is three times that of the general population.

I have seen the hard reality of these statistics in the families of Arizona tribes as well as tribes across the Nation. Methamphetamine addiction, diabetes, alcoholism, and heart disease are epidemics devastating the Indian people. Our trust obligation dictates we address these health crises on reservations, and I strongly support actions to that effect. However, as I stated before,

using taxpayer money to promote abortion services is something I find highly objectionable and will vehemently oppose. I strongly urge my colleagues to support efforts to strike these unacceptable provisions and enable this bill, which is of critical importance to Indian country, to be approved.●

Mr. SANDERS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. THUNE. Mr. President, is the pending business S. 1200, the Indian Health Care Improvement Act Amendments of 2007?

The PRESIDING OFFICER. That is correct.

Mr. THUNE. Mr. President, I wish to speak to that legislation. The Indian Health Care Improvement Act is before the Senate today and tomorrow and hopefully will be completed, and we will be able to vote on some amendments and finally get this legislation reauthorized because it is very long overdue and the need for its completion cannot be underestimated.

I represent nine tribes in my State of South Dakota, and in any given year, depending on the year we are talking about, as many as five of those reservation counties in South Dakota will be in the top 10 poorest counties in America. These are areas in my State that are struggling in so many different ways where many of the basic services that those of us who live off the reservations expect on a daily basis are just not available.

One of the things that is desperately needed is access to health care, making sure there is quality health care available to people on the reservations.

The Indian Health Care Improvement Act reauthorization has really been in the works since 1999–2000. I think the 106th Congress was the last time this issue was debated. We have been trying since that time to get this bill on the floor and get it reauthorized. It is a critical piece of legislation that is so important to the people whom I represent and to tribes all across this country and to Native American people.

To give an example of what I am talking about, in South Dakota, between 2000 and 2005, Native American infants were more than twice as likely to die as White infants. Nationally, Native Americans are three times as likely to die from diabetes as compared to the rest of the population in the country.

In South Dakota, a recent survey found that 13 percent of Native Americans suffered from diabetes. This is twice the rate of the general population in which only 6 percent are suffering from diabetes.

An individual who is served by IHS is 6.5 times more likely to suffer an alcohol-related death than the general population. An individual served by an IHS facility is 50 percent more likely to commit suicide than the general population.

I appreciate the time the Senate is taking to debate this bill and the serious health issues this bill hopes to address and correct. I especially thank the Indian Affairs Committee for working with me to help the Yankton Sioux Tribe of South Dakota keep the Wagner emergency room open. Our delegation from South Dakota has been working for some time in making sure that members of the Yankton Sioux Tribe have access to emergency room service 24 hours a day, which is critically important.

The committee was very helpful in making sure that issue was addressed in this authorization. I thank them for that help and appreciate their work in working with us to that end.

I also thank them for the work they have done to ensure that the Urban Indian Health Program remains a viable and helpful program for Native Americans who live off the reservation.

I am also a cosponsor of an amendment that has been offered by Senator VITTER. I reiterate my support for extending the Hyde language of this bill in preventing Federal funds being spent on abortions, except in cases where the life of the mother is at stake or in case of incest or rape.

I also reiterate my support for Senator BINGAMAN's amendment. I am a cosponsor of that amendment which will extend Medicare payment rates to all Medicare providers who accept IHS contracting agreements.

This amendment hopefully will stretch IHS contracting dollars even further and help reduce, even if it is only in a small way, some of the shortfalls that currently exist.

This legislation goes a long way in attempting to improve health care throughout Indian country. However, we have to remember there is still more, lots more, that we need to do, especially in the area of tribal justice and law enforcement in order to help improve the lives of individuals who live on and near Indian reservations throughout the country.

Last year, I worked hard to improve tribal justice and law enforcement on Indian reservations, and I look forward to partnering with my colleagues in the Senate to continue that fight this year to make sure we have adequate law enforcement personnel, that we have an adequate number of prosecutors so that when crimes are committed, they can be prosecuted. But we have to address these very fundamental issues if we are going to improve the quality of life for people on the reservations.

As I travel the reservations in South Dakota—and I was at the Rosebud Indian Reservation just this last week—what strikes me is, people on the reservations, just as those I represent who live off the reservations, want the same thing: They want a better life for their children, for their grandchildren, for future generations. They want to make sure they have security and there is adequate law enforcement and they do not have to live in fear when it comes to the issues of crime. They want to make sure their children have access to quality education and a responsibility that many of us take very seriously, ensuring and seeing to it that young people, children on the reservation, have an opportunity to learn at the very fastest rate possible, to go through elementary and secondary school and then on to higher education if they choose to.

A number of the tribal colleges we support in many cases suffer, again, from a lack of funding. They also have to have basic health care services, which is what this bill attempts to address. Whether it is in the area of dental care, whether it is in the area of basic primary care, speciality care, the IHS facilities on the reservations suffer from being unable to recruit and retain health care providers. Whether it is physicians or dentists—and that is an issue we face as well—we need to make sure we have the right incentives in place to attract health care providers to serve in reservation areas.

This bill, as it is currently structured, I believe, will help to address that very basic expectation that all people who live on reservations have, and that is, when they have a need, they will have access to quality health care to address those needs.

This bill will be debated again tomorrow in the Senate, probably, I hope, voted on sometime tomorrow so that we can finally get this reauthorization bill through. It has been teed up for some time.

I appreciate the work the chairman, Senator DORGAN from North Dakota, and Senator MURKOWSKI from Alaska, the ranking Republican, have done to bring this bill to the floor and, as I said before, to work with us on issues important to South Dakota.

I am also happy to cosponsor a couple of amendments that I hope can be adopted—the Vitter amendment and, as I said earlier, the Bingaman amendment, which will help make health care more available and take the dollars of the IHS and stretch them further when it comes to contracting services.

I urge my colleagues in the Senate to vote for this bill. This should be a big bipartisan vote. If anybody cares seriously about improving the quality of life on reservations in this country and addressing what are deep economic needs, it starts with some of these very basic services. It starts with law enforcement security, it starts with education, and it starts with health care, and I think this bill takes us a long way in the direction of dealing with the health care issues that affect so many of our tribes in this country.

I hope my colleagues in a very big bipartisan way will vote for this legislation, support it, and hopefully get it signed into law before this year is out.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BROWN). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. CASEY. Mr. President, I ask unanimous consent that there now be a period for the transaction of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

TRIBUTE TO JOHN STROGER

Mr. DURBIN. Mr. President, tomorrow, the city of Chicago and Cook County, IL, will say goodbye to a legend.

John Stroger was born into poverty in Arkansas at the start of the Great Depression. He lived to become the first African American ever elected president of the Board of Commissioners of Cook County, IL. He lived to be one of the most powerful politicians in my home State.

He died at 8 o'clock last Friday morning from complications of a stroke he suffered almost 2 years ago and from which he never fully recovered.

John Stroger was 78 years old.

Mayor Daley confirmed the passing of John Stroger at a prayer breakfast on that day when we were honoring Dr. Martin Luther King. What a fitting coincidence. Dr. King had told us:

> Everybody can be great, because everyone can serve.

John Stroger spent his life serving.

John Stroger was a grandson of former slaves who believed in the promise of America and believed that government can and should be a force for progress.

He was a man of compassion, integrity, great humor, and great political skill. He used all of those qualities to help others.

He spent his political life breaking down racial barriers and working to lift up those who were less fortunate. His lifelong commitment to serve those who struggle every day to find affordable, quality medical care will certainly be his legacy.

Many years ago, John Stroger befriended me when I was an unknown candidate from Springfield with a few friends in the Chicago political world. For me, John Stroger was more than an ally. He was a great friend.

He was also a man of strong opinions. Our mutual friend, Congressman DANNY DAVIS of Illinois, once joked that John Stroger ''would argue with a signpost.'' But he never held grudges. He was a real gentleman.

He was also a champion for working families and the poor. As Cook County board president from 1994 to 2006, John Stroger opened doors of opportunity in government and business for women and minorities and improved the county's bond rating.

He made county government more responsive by changing the way commissioners are elected.

He created a special domestic violence court.

And then there is the achievement of which he was probably most proud: the construction in the year 2002 of a state-of-the-art hospital to serve the poor, the uninsured, and the underserved of Cook County and the Chicagoland area.

At a time when public hospitals across America are having to turn people away, John Stroger still believed that every person deserved the dignity and security of basic health care and lifesaving medicine.

The Chicago Sun Times noted:

> John Stroger was so much larger than life they did not even wait until he was dead to put his name on the Cook County Hospital he defied the critics to build.

The John H. Stroger Hospital of Cook County, IL, is just one way that the legacy of this remarkable man will continue to serve the people and city he loved for years to come.

Mr. President, I remember when John Stroger decided that this hospital was going to be built. There were scores of critics. Why in the world would we want to build a hospital for poor people? John Stroger knew the answer to that question. It was an answer from his heart: Because that is what America does. America cares for the poor. America provides the poor in Cook County and all across our Nation with the same kind of quality care that we all want for our families.

John Stroger knew that. His battle for that hospital ended up in one of the great success stories of public life in Illinois.

John Stroger was born in 1929 in Helena, AR—the oldest of four kids. His father was a tailor, his mother worked as a maid. The family lived in a three-room shack with no electricity and no indoor plumbing.

John Stroger later described it for a Sun Times reporter when he said: ''We didn't have any boots, and we didn't have any straps.''

He graduated from Xavier College in New Orleans in 1952 with a degree in business administration. He was proud of Xavier to the last day I ever spoke to him. He always spoke with great pride about that college. He moved back to Arkansas and spent a year teaching high school math and coaching basketball. When he came home one day, his mom had packed a suitcase. She told him she had arranged for him to move to Chicago because there would be more opportunities for a young black man.

John Stroger had caught the political bug years earlier. After hearing a speaker in Arkansas say that the election of President Harry Truman would lead to full rights for African Americans, he had organized voters and tried to persuade them to pay the poll tax so they could vote.

In Chicago, there was no poll tax, but there were other obstacles to full political participation for African Americans in the 1950s. Over the next four decades, John Stroger fought them all.

In 1968, he was named Democratic committeeman for South Side's Eighth ward—the first African-American committeeman for that famous ward. Two years later, John was elected to the Cook County Board. In 1994, he became board president. He was running for his fourth term in 2006 when he suffered a stroke a week before the primary.

John was my friend. The last picture we had taken together was at the St. Patrick's Day march, a legendary march in Chicago. There was John, with his big smile and big green sash, standing next to me and Mayor Daley. I am going to treasure that photo. I think it was one of the last taken of John as a candidate.

After he suffered a stroke, the Chicago Tribune ran an editorial that read, in part:

> If John Stroger ever anticipated a career farewell, he surely saw himself shaking hands with everyone—his allies, his adversaries, the bypassers captivated if only for a moment by one of the more genuine personalities in Chicago politics.

The Tribune went on to write:

> But he likely didn't anticipate a farewell. He wouldn't have enjoyed those elaborate exercises in staged finality. Politics and governance were his life; an intimate says the prospect of retirement unnerved him. Even in this awkward moment, we know he leaves public office just as he occupied it: Without a grudge, without a complaint, and with precious few regrets.

Those were the words of the Chicago Tribune, not always John Stroger's political friend.

The mayor and Members of Congress and the city council and even a former President of the United States have praised John Stroger's life and legacy these past days—and rightly so. But I think the eulogy John Stroger would have liked best wasn't offered by a politician.

Clyde Black runs a shoeshine operation in the City Hall-County Building complex in Chicago. Years ago, John Stroger gave him a helping hand to start his little business. As word of President Stroger's death spread last Friday, Clyde Black told a reporter:

> He changed my life—made me a better person. He's someone we all dearly miss a lot.

It is a sentiment I and many others share.

I offer my deep condolences to President Stroger's family, especially his wife Yonnie. What a wonderful woman, by his side throughout his political life