efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1090

At the request of Mr. WYDEN, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1090, a bill to amend the Internal Revenue Code of 1986 to provide tax credit parity for electricity produced from renewable resources.

S. 1157

At the request of Mr. CONRAD, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 1157, a bill to amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.

S.J. RES. 15

At the request of Mr. VITTER, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S.J. Res. 15, a joint resolution proposing an amendment to the Constitution of the United States authorizing the Congress to prohibit the physical desecration of the flag of the United States.

S. CON. RES. 14

At the request of Mrs. LINCOLN, the names of the Senator from Montana (Mr. TESTER) and the Senator from Missouri (Mr. BOND) were added as cosponsors of S. Con. Res. 14, a concurrent resolution supporting the Local Radio Freedom Act.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BINGAMAN (for himself and Mrs. LINCOLN):

S. 1161. A bill to amend the Public Health Service Act to authorize programs to increase the number of nurse faculty and to increase the domestic nursing and physical therapy workforce, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. BINGAMAN. Mr. President, I rise today with my colleague Senator LINCOLN to introduce the Nurse Faculty and Physical Therapist Education Act of 2009. This legislation will help to address the critical shortage of nurse faculty and physical therapists that is facing our Nation. The nationwide nursing shortage is growing rapidly, because the average age of the nursing workforce is near retirement and because the aging population has increased health care needs. The shortage is one that affects the entire Nation. A 2006 Health Resources and Services Administration, HRSA, report estimated that the national nursing shortage would more than triple, to more than one million nurses, by the year 2020. The report also predicts that all 50 States will experience nursing shortages by 2015. Quite simply, we need to educate more nurses, or we, as a Nation, will not have enough trained nurses to meet the needs of our aging society.

One of the biggest constraints to educating more nurses is a shortage of nursing faculty. Almost three-quarters of nursing programs surveyed by the American Association of Colleges of Nursing cited faculty shortages as a reason for turning away qualified applicants. Although applications to nursing programs have surged 59 percent over the past decade, the National League for Nursing estimates that 147,000 qualified applications were turned away in 2004. This represents a 27 percent decrease in admissions over the previous year, indicating the need to scale up capacity in nursing programs is more critical than ever.

I know that in my home State of New Mexico, nursing programs turned down almost half of qualified applicants, even though HRSA predicts that New Mexico will only be able to meet 64 percent of its demand for nurses by 2020. With a national nurse faculty workforce that averages 53.5 years of age, and an average nurse faculty retirement age of 62.5 years, we cannot and must not wait any longer to address nurse faculty shortages.

Nursing faculty are not the only segment of the population that is aging. As the baby boom generation ages, there will be an increased need for nurses to care for the elderly. However, less than one percent of practicing nurses have a certification in geriatrics.

The Nurse Faculty and Physical Therapist Education Act will amend the Public Health Service Act, to help alleviate the faculty shortage by providing funds to help nursing schools increase enrollment and graduation from nursing doctoral programs. The act will increase partnering opportunities between academic institutions and medical practices, enhance cooperative education, support marketing outreach, and strengthen mentoring programs. The bill will increase the number of nurses who complete nursing doctoral programs and seek employment as faculty members and nursing leaders in academic institutions. In addition, the bill authorizes awards to train nursing faculty in clinical geriatrics, so that more nursing students will be equipped for our aging population.

By addressing the faculty shortage, we are addressing the nursing shortage.

The aging population will also require additional health workers in other fields. Physical therapy was listed as one of the fastest growing occupations by the U.S. Department of Labor, with a projected job growth of greater than 36 percent between 2004 and 2014. The need for physical therapists is particularly acute in rural and urban underserved areas, which have three to four times fewer physical therapists per capita than suburban areas. To address this need, the bill also authorizes a distance education pilot program to improve access to educational opportunity for both nursing and physical therapy students. Finally, the bill calls for a study by the Institute of Medicine at the National Academy of Sciences which will recommend how to balance education, labor, and immigration policies to meet the demand for qualified nurses and physical therapists.

The provisions of the Nurse Faculty and Physical Therapist Education Act are vital to overcoming workforce challenges. By addressing nurse faculty and physical therapist shortages, we will enhance both access to care and the quality of care.

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

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

S. 1161

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

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Nurse Faculty and Physical Therapist Education Act of 2009''.

(b) FINDINGS.—Congress makes the following findings:

(1) The Nurse Reinvestment Act (Public Law 107–205) has helped to support students preparing to be nurse educators. Yet, nursing schools nationwide are forced to deny admission to individuals seeking to become nurses and nurse educators due to the lack of qualified nurse faculty.

(2) The American Association of Colleges of Nursing reported that 42,866 qualified applicants were denied admission to nursing baccalaureate and graduate programs in 2006, with faculty shortages identified as a major reason for turning away students.

(3) Seventy-one percent of schools have reported insufficient faculty as the primary reason for not accepting qualified applicants. The primary reasons for lack of faculty are lack of funds to hire new faculty, inability to identify, recruit and hire faculty in the competitive job market as of May 2007, and lack of nursing faculty available in different geographic areas.

(4) Despite the fact that in 2006, 52.4 percent of graduates of doctoral nursing programs enter education roles, the 103 doctoral programs nationwide produced only 437 graduates, which is only an additional 6 graduates from 2005. This annual graduation rate is insufficient to meet the needs for nurse faculty. In keeping with other professional academic disciplines, nurse faculty at colleges and universities are typically doctorally prepared.

(5) The nursing faculty workforce is aging and will be retiring.

(6) With the average retirement age of nurse faculty at 62.5 years of age, and the average age of doctorally prepared faculty, as of May 2007, that hold the rank of professor, associate professor, and assistant professor is 58.6, 55.8, and 51.6 years, respectively, the health care system faces unprecedented workforce and health access challenges with current and future shortages of deans, nurse educators, and nurses.

(7) Research by the National League of Nursing indicates that by 2019 approximately 75 percent of the nursing faculty population (as of May 2007) is expected to retire.

(8) A wave of nurses will be retiring from the profession in the near future. As of May 2007, the average age of a nurse in the United States is 46.8 years old. The Bureau of Labor Statistics estimates that more than 1,200,000 new and replacement registered nurses will be needed by 2014.

(9) By 2030, the number of adults age 65 and older is expected to double to 70,000,000, accounting for 20 percent of the population. As the population ages, the demand for nurses and nursing faculty will increase.

(10) Despite the need for nurses to treat an aging population, few registered nurses in the United States are trained in geriatrics. Less than 1 percent of practicing nurses have a certification in geriatrics and 3 percent of advanced practice nurses specialize in geriatrics.

(11) Specialized training in geriatrics is needed to treat older adults with multiple health conditions and improve health outcomes. Approximately 80 percent of Medicare beneficiaries have 1 chronic condition, more than 60 percent have 2 or more chronic conditions, and at least 10 percent have coexisting Alzheimer's disease or other dementias that complicate their care and worsen health outcomes. Two-thirds of Medicare spending is attributed to 20 percent of beneficiaries who have 5 or more chronic conditions. Research indicates that older persons receiving care from nurses trained in geriatrics are less frequently readmitted to hospitals or transferred from nursing facilities to hospitals than those who did not receive care from a nurse trained in geriatrics.

(12) The Department of Labor projected that the need for physical therapists would increase by 36.7 percent between 2004 and 2014.

(13) The need for physical therapists is particularly acute rural and urban underserved areas, which have 3 to 4 times fewer physical therapists per capita than suburban areas.

TITLE I—GRANTS FOR NURSING EDUCATION

SEC. 101. NURSE FACULTY EDUCATION.

Part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by adding at the end the following:

"SEC. 832. NURSE FACULTY EDUCATION.

''(a) ESTABLISHMENT.—The Secretary, acting through the Health Resources and Services Administration, shall establish a Nurse Faculty Education Program to ensure an adequate supply of nurse faculty through the awarding of grants to eligible entities to—

''(1) provide support for the hiring of new faculty, the retaining of existing faculty, and the purchase of educational resources;

''(2) provide for increasing enrollment and graduation rates for students from doctoral programs; and

''(3) assist graduates from the entity in serving as nurse faculty in schools of nursing;

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be an accredited school of nursing that offers a doctoral degree in nursing in a State or territory;

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(3) develop and implement a plan in accordance with subsection (c);

''(4) agree to submit an annual report to the Secretary that includes updated information on the doctoral program involved, including information with respect to—

''(A) student enrollment;

''(B) student retention;

''(C) graduation rates;

''(D) the number of graduates employed part-time or full-time in a nursing faculty position; and

''(E) retention in nursing faculty positions within 1 year and 2 years of employment;

''(5) agree to permit the Secretary to make on-site inspections, and to comply with the requests of the Secretary for information, to determine the extent to which the school is complying with the requirements of this section; and

''(6) meet such other requirements as determined appropriate by the Secretary.

''(c) USE OF FUNDS.—Not later than 1 year after the receipt of a grant under this section, an entity shall develop and implement a plan for using amounts received under this grant in a manner that establishes not less than 2 of the following:

''(1) Partnering opportunities with practice and academic institutions to facilitate doctoral education and research experiences that are mutually beneficial.

''(2) Partnering opportunities with educational institutions to facilitate the hiring of graduates from the entity into nurse faculty, prior to, and upon completion of the program.

''(3) Partnering opportunities with nursing schools to place students into internship programs which provide hands-on opportunity to learn about the nurse faculty role.

''(4) Cooperative education programs among schools of nursing to share use of technological resources and distance learning technologies that serve rural students and underserved areas.

''(5) Opportunities for minority and diverse student populations (including aging nurses in clinical roles) interested in pursuing doctoral education.

''(6) Pre-entry preparation opportunities including programs that assist returning students in standardized test preparation, use of information technology, and the statistical tools necessary for program enrollment.

''(7) A nurse faculty mentoring program.

''(8) A Registered Nurse baccalaureate to Ph.D. program to expedite the completion of a doctoral degree and entry to nurse faculty role.

''(9) Career path opportunities for 2nd degree students to become nurse faculty.

''(10) Marketing outreach activities to attract students committed to becoming nurse faculty.

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities from States and territories that have a lower number of employed nurses per 100,000 population.

''(e) NUMBER AND AMOUNT OF GRANTS.—Grants under this section shall be awarded as follows:

''(1) In fiscal year 2010, the Secretary shall award 10 grants of $100,000 each.

''(2) In fiscal year 2011, the Secretary shall award an additional 10 grants of $100,000 each and provide continued funding for the existing grantees under paragraph (1) in the amount of $100,000 each.

''(3) In fiscal year 2012, the Secretary shall award an additional 10 grants of $100,000 each and provide continued funding for the existing grantees under paragraphs (1) and (2) in the amount of $100,000 each.

''(4) In fiscal year 2013, the Secretary shall provide continued funding for each of the existing grantees under paragraphs (1) through (3) in the amount of $100,000 each.

''(5) In fiscal year 2014, the Secretary shall provide continued funding for each of the existing grantees under paragraphs (1) through (3) in the amount of $100,000 each.

''(f) LIMITATIONS.—

''(1) PAYMENT.—Payments to an entity under a grant under this section shall be for a period of not to exceed 5 years.

''(2) IMPROPER USE OF FUNDS.—An entity that fails to use amounts received under a grant under this section as provided for in subsection (c) shall, at the discretion of the Secretary, be required to remit to the Federal Government not less than 80 percent of the amounts received under the grant.

''(g) REPORTS.—

''(1) EVALUATION.—The Secretary shall conduct an evaluation of the results of the activities carried out under grants under this section.

''(2) REPORTS.—Not later than 3 years after the date of the enactment of this section, the Secretary shall submit to Congress an interim report on the results of the evaluation conducted under paragraph (1). Not later than 6 months after the end of the program under this section, the Secretary shall submit to Congress a final report on the results of such evaluation.

''(h) STUDY.—

''(1) IN GENERAL.—Not later than 3 years after the date of the enactment of this section, the Comptroller General of the United States shall conduct a study and submit a report to Congress concerning activities to increase participation in the nurse educator program under the section.

''(2) CONTENTS.—The report under paragraph (1) shall include the following:

''(A) An examination of the capacity of nursing schools to meet workforce needs on a nationwide basis.

''(B) An analysis and discussion of sustainability options for continuing programs beyond the initial funding period.

''(C) An examination and understanding of the doctoral degree programs that are successful in placing graduates as faculty in schools of nursing.

''(D) An analysis of program design under this section and the impact of such design on nurse faculty retention and workforce shortages.

''(E) An analysis of compensation disparities between nursing clinical practitioners and nurse faculty and between higher education nurse faculty and higher education faculty overall.

''(F) Recommendations to enhance faculty retention and the nursing workforce.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For the costs of carrying out this section (except the costs described in paragraph (2), there are authorized to be appropriated $1,000,000 for fiscal year 2010, $2,000,000 for fiscal year 2011, and $3,000,000 for each of fiscal years 2012 through 2014.

''(2) ADMINISTRATIVE COSTS.—For the costs of administering this section, including the costs of evaluating the results of grants and submitting reports to the Congress, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 102. GERIATRIC ACADEMIC CAREER AWARDS FOR NURSES.

Part I of title VIII of the Public Health Service Act (42 U.S.C. 298 et seq.) is amended by adding at the end the following:

"SEC. 856. GERIATRIC FACULTY FELLOWSHIPS.

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program to provide Geriatric Academic Career Awards to eligible individuals to promote the career development of such individuals as geriatric nurse faculty.

''(b) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under subsection (a), an individual shall—

''(1) be a registered nurse with a doctorate degree in nursing;

''(2)(A) have completed an approved advanced education nursing program in geriatric nursing or geropsychiatric nursing; or

''(B) have a State or professional nursing certification in geriatric nursing or geropsychiatric nursing; and

''(3) have a faculty appointment at an accredited school of nursing, school of public health, or school of medicine.

''(c) APPLICATION.—An eligible individual desiring to receive an Award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, which shall include an assurance that the individual will meet the service requirement described in subsection (d).

''(d) SERVICE REQUIREMENT.—An individual who receives an Award under this section shall provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals. The provision of such training shall constitute at least 50 percent of the obligations of such individual under the Award.

''(e) AMOUNT AND NUMBER.—

''(1) AMOUNT.—The amount of an Award under this section shall equal $75,000 annually, adjusted for inflation on the basis of the Consumer Price Index. The Secretary may increase the amount of an Award by not more than 25 percent, taking into account the fringe benefits and other research expenses, at the recipient's institutional rate.

''(2) NUMBER.—The Secretary shall award up to 125 Awards under this section from 2008 through 2016.

''(3) REGIONAL DISTRIBUTION.—

''(A) IN GENERAL.—The Secretary shall provide Awards to individuals from 5 regions in the United States, of which—

''(i) 2 regions shall be an urban area;

''(ii) 2 regions shall be a rural area; and

''(iii) 1 region shall include a State with—

''(I) a medical school that has a department of geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, 1 of which is dementia; and

''(II) a college of nursing that has a required course in geriatric nursing in the baccalaureate program.

''(B) GEOGRAPHIC DIVERSITY.—The Secretary shall ensure that the 5 regions established under subparagraph (A) are located in different geographic areas of the United States.

''(f) TERM OF AWARD.—The term of an Award made under this section shall be 5 years.

''(g) REPORTS.—

''(1) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of the results of the activities carried out under the Awards established under this section.

''(B) REPORTS TO CONGRESS.—Not later than 3 years after the date of the enactment of this section, the Secretary shall submit to Congress an interim report on the results of the evaluation conducted under this paragraph. Not later than 180 days after the expiration of the program under this section, the Secretary shall submit to Congress a final report on the results of such evaluation.

''(2) CONTENT.—The evaluation under paragraph (1) shall examine—

''(A) the program design under this section and the impact of the design on nurse faculty retention; and

''(B) options for continuing the program beyond fiscal year 2018.

''(h) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To fund Awards under subsection (e), there are authorized to be appropriated $1,875,000 for each of fiscal years 2010 through 2018.

''(2) ADMINISTRATIVE COSTS.—To carry out this section (except to fund Awards under subsection (e)), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2016.

''(3) SEPARATION OF FUNDS.—The Secretary shall ensure that the amounts appropriated pursuant to paragraph (1) are held in a separate account from the amounts appropriated pursuant to paragraph (2).''.

TITLE II—DISTANCE EDUCATION PILOT PROGRAM AND OTHER PROVISIONS TO INCREASE THE NURSING AND PHYSICAL THERAPY WORKFORCE

SEC. 201. INCREASING THE DOMESTIC SUPPLY OF NURSES AND PHYSICAL THERAPISTS.

(a) ESTABLISHMENT OF NURSE AND PHYSICAL THERAPISTS DISTANCE EDUCATION PILOT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in conjunction with the Secretary of Education, shall establish a Nurse and Physical Therapist Distance Education Pilot Program through which grants may be awarded for the conduct of activities to increase accessibility to nursing and physical therapy education.

(2) PURPOSE.—The purpose of the Nurse and Physical Therapist Distance Education Pilot Program established under paragraph (1) shall be to increase accessibility to nursing and physical therapy education to—

(A) provide assistance to individuals in rural areas who want to study nursing or physical therapy to enable such individuals to receive appropriate nursing education and physical therapy education;

(B) promote the study of nursing and physical therapy at all educational levels;

(C) establish additional slots for nursing and physical therapy students at existing accredited schools of nursing and physical therapy education programs; and

(D) establish new nursing and physical therapy education programs at institutions of higher education.

(3) APPLICATION.—To be eligible to receive a grant under the Pilot Program under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(b) INCREASING THE DOMESTIC SUPPLY OF NURSES AND PHYSICAL THERAPISTS.—

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary, in conjunction with the Secretary of Education, shall—

(A) submit to Congress a report concerning the country of origin or professional school of origin of newly licensed nurses and physical therapists in each State, that shall include—

(i) for the most recent 3-year period for which data is available—

(I) separate data relating to teachers at institutions of higher education for each related occupation who have been teaching for not more than 5 years; and

(II) separate data relating to all teachers at institutions of higher education for each related occupation regardless of length of service;

(ii) for the most recent 3-year period for which data is available, separate data for each related occupation and for each State;

(iii) a separate identification of those individuals receiving their initial professional license and those individuals licensed by endorsement from another State;

(iv) with respect to those individuals receiving their initial professional license in each year, a description of the number of individuals who received their professional education in the United States and the number of individuals who received such education outside the United States; and

(v) to the extent practicable, a description, by State of residence and country of education, of the number of nurses and physical therapists who were educated in any of the 5 countries (other than the United States) from which the most nurses and physical therapists arrived;

(B) in consultation with the Department of Labor, enter into a contract with the Institute of Medicine of the National Academy of Sciences for the conduct of a study and submission of a report that includes—

(i) a description of how the United States can balance health, education, labor, and immigration policies to meet the respective policy goals and ensure an adequate and well-trained nursing and physical therapy workforce;

(ii) a description of the barriers to increasing the supply of nursing and physical therapy faculty, domestically trained nurses, and domestically trained physical therapists;

(iii) recommendations of strategies to be utilized by Federal and State governments that would be effective in removing the barriers described in clause (ii), including strategies that address barriers to advancement to become registered nurses for other health care workers, such as home health aides and nurses assistants;

(iv) recommendations for amendments to Federal laws that would increase the supply of nursing faculty, domestically trained nurses, and domestically trained physical therapists;

(v) recommendations for Federal grants, loans, and other incentives that would provide increases in nurse and physical therapist educators and training facilities, and other measures to increase the domestic education of new nurses and physical therapists;

(vi) an identification of the effects of nurse and physical therapist emigration on the health care systems in their countries of origin; and

(vii) recommendations for amendments to Federal law that would minimize the effects of health care shortages in the countries of origin from which immigrant nurses arrived; and

(C) collaborate with the heads of other Federal agencies, as appropriate, in working with ministers of health or other appropriate officials of the 5 countries from which the most nurses and physical therapists arrived into the United States, to—

(i) address health worker shortages caused by emigration; and

(ii) ensure that there is sufficient human resource planning or other technical assistance needed to reduce further health worker shortages in such countries.

(2) ACCESS TO DATA.—The Secretary shall grant the Institute of Medicine access to the data described under paragraph (1)(A), as such data becomes available to the Secretary for use by the Institute in carrying out the activities under paragraph (1)(B).

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $1,400,000 to carry out paragraph (1)(B).

By Mr. FEINGOLD (for himself and Ms. COLLINS):

S. 1164. A bill to amend the Public Health Service Act to reauthorize the Automated Defibrillation in Adam's Memory Act; to the Committee on Health, Education, Labor, and Pensions.

Mr. FEINGOLD. Mr. President, today I am introducing the reauthorization of

the Automated Defibrillators in Adam's Memory Act, or the ADAM Act. This bill is modeled after the successful Project ADAM that originally began in Wisconsin, and will reauthorize a program to establish a national clearing house to provide schools with the ''how-to'' and technical advice to set up a public access defibrillation program.

Every 2 minutes, someone in America falls into sudden cardiac arrest. By improving access to AEDs, we can improve the survival rates of cardiac arrest in our communities.

In my home State of Wisconsin, as in many other states, heart disease is the number one killer. Nationwide, heart disease is the cause of one out of every 2.8 deaths. Overall, heart disease kills more Americans than breast cancer, lung cancer, and HIV/AIDS combined.

Cardiac arrest can strike anyone. Cardiac victims are in a race against time, and unfortunately, for too many of those in rural areas, Emergency Medical Services are unable to reach people in need, and time runs out for victims of cardiac arrest. It's simply not possible to have EMS units next to every farm and small town across the nation.

Fortunately, recent technological advances have made the newest generation of AEDs inexpensive and simple to operate. Because of these advancements in AED technology, it is now practical to train and equip police officers, teachers, and members of other community organizations.

Over 163,000 Americans experience out-of-hospital sudden cardiac arrests each year. Immediate CPR and early defibrillation using an automated external defibrillator, AED, can more than double a victim's chance of survival. By taking some relatively simple steps, we can give victims of cardiac arrest a better chance of survival.

Over the past 9 years, I have worked with Senator SUSAN COLLINS, a Republican from Maine, on a number of initiatives to empower communities to improve cardiac arrest survival rates. We have pushed Congress to support rural first responders—local police and fire and rescue services—in their efforts to provide early defibrillation. Congress heard our call, and responded by enacting two of our bills, the Rural Access to Emergency Devices Act and the ADAM Act.

The Rural Access to Emergency Devices program allows community partnerships across the country to receive a grant enabling them to purchase defibrillators, and receive the training needed to use these devices. This program is entering its ninth year of helping rural communities purchase defibrillators and train first responders, and I am pleased to say that grants have already put defibrillators in rural communities all over the country, helping those communities be better prepared when cardiac arrest strikes.

Approximately ninety-five percent of sudden cardiac arrest victims die before reaching the hospital. Every minute that passes before a cardiac arrest victim is defibrillated, the chance of survival falls by as much as 10 percent. After only eight minutes, the victim's survival rate drops by 60 percent. This is why early intervention is essential—a combination of CPR and use of AEDs can save lives.

Heart disease is not only a problem among adults. A few years ago I learned the story of Adam Lemel, a 17-year-old high school student and a star basketball and tennis player in Wisconsin. Tragically, during a timeout while playing basketball at a neighboring Milwaukee high school, Adam suffered sudden cardiac arrest, and died before the paramedics arrived.

This story is incredibly tragic. Adam had his whole life ahead of him, and could quite possibly have been saved with appropriate early intervention. In fact, we have seen a number of examples in Wisconsin where early CPR and access to defibrillation have saved lives.

Seventy miles away from Milwaukee, a 14-year-old boy collapsed while playing basketball. Within three minutes, the emergency team arrived and began CPR. Within five minutes of his collapse, the paramedics used an AED to jump start his heart. Not only has this young man survived, doctors have identified his father and brother as having the same heart condition and have begun preventative treatments.

These stories help to underscore some important issues. First, although cardiac arrest is most common among adults, it can occur at any age—even in apparently healthy children and adolescents. Second, early intervention is essential—a combination of CPR and the use of AEDs can save lives. Third, some individuals who are at risk for sudden cardiac arrest can be identified.

After Adam Lemel suffered his cardiac arrest, his friend David Ellis joined forces with Children's Hospital of Wisconsin to initiate Project ADAM to bring CPR training and public access defibrillation into schools, educate communities about preventing sudden cardiac deaths and save lives.

Today, Project ADAM has introduced AEDs into several Wisconsin schools, and has been a model for programs in Washington, Florida, Michigan and elsewhere. Project ADAM provides a model for the nation, and now, with the enactment of this new law, more schools will have access to the information they seek to launch similar programs.

The ADAM Act was passed into law in 2003, but has yet to be funded. I have been very proud to play a part in having this bill signed into law, and it is my hope that the reauthorization of the Act will quickly pass through the Congress and into law, and that funding will follow. It would not take much money to fund this program and save lives across the country.

The ADAM Act is one way we can honor the life of children like Adam Lemel, and give tomorrow's pediatric cardiac arrest victims a fighting chance at life.

This act exists because a family experienced the tragic loss of their son, but they were determined to spare other families that same loss. I thank Adam's parents, Joe and Patty, for their courageous efforts and I thank them for everything they have done to help the ADAM Act become law. Their actions take incredible bravery, and I commend them for their efforts.

By making sure that AEDs are available in our nation's rural areas, schools and throughout our communities we can help those in a race against time have a fighting chance of survival when they fall victim to cardiac arrest. I urge Congress to pass this reauthorization, and to fund the ADAM Act and the Rural AED program at their full levels. We have the power to prevent death—all we must do is act.

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

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

S. 1164

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Automated Defibrillation in Adam's Memory Reauthorization Act''.

SEC. 2. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 244) is amended—

(1) in subsection (c)(6), after ''clearinghouse'' insert '', that shall be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death,''; and

(2) in the first sentence of subsection (e), by striking ''fiscal year 2003'' and all that follows through ''2006'' and inserting ''for each of fiscal years 2003 through 2014''.

By Mr. FEINGOLD (for himself and Ms. COLLINS):

S. 1165. A bill to promote the development of health care cooperatives that will help businesses to pool the health care purchasing power of employers, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. FEINGOLD. Mr. President, today, along with my colleague Senator COLLINS from Maine, I am reintroducing legislation to help businesses form group-purchasing cooperatives to obtain enhanced benefits, to reduce health care rates, and to improve quality for their employees' health care.

High health care costs are burdening businesses and employees across the nation. These costs are digging into profits and preventing access to affordable health care. Too many patients feel trapped by the system, with decisions about their health dictated by costs rather than by what they need.

Nationally, the annual average cost to an employer for an individual employee's health care is $3,983. For a

family, the employer contribution is $9,325. We must curb these rapidly increasing health care costs. I strongly support initiatives to ensure that everyone has access to health care. It is crucial that we support successful local initiatives to reduce health care premiums and to improve the quality of employees' health care.

By using group purchasing to obtain rate discounts, some employers have been able to reduce the cost of health care premiums for their employees. According to the National Business Coalition on Health, there are nearly 60 employer-led coalitions across the U.S. that collectively purchase health care. Through these pools, businesses are able to proactively challenge high costs and inefficient delivery of health care and share information on quality. These coalitions represent over 7,000 employers nationwide.

Improving the quality of health care will also lower the cost of care. By investing in the delivery of high-quality health care, we will be able to lower long term health care costs. Effective care, such as high-quality preventive services, can reduce overall health care expenditures. Health purchasing coalitions help promote these services and act as an employer forum for networking and education on health care cost containment strategies. They can help foster a dialogue with health care providers, insurers, and local HMOs.

Health care markets are local. Problems with cost, quality, and access to health care are felt most intensely in the local markets. Health care coalitions can function best when they are formed and implemented locally. Local employers of large and small businesses have formed health care coalitions to track health care trends, create a demand for quality and safety, and encourage group purchasing.

In Wisconsin, there have been various successful initiatives that have formed health care purchasing cooperatives to improve quality of care and to reduce cost. For example, the Employer Health Care Alliance Cooperative, an employer-owned and employer-directed not-for-profit cooperative, has developed a network of health care providers in Dane County and 13 surrounding counties on behalf of more than 160 member employers. Through this pooling effort, employers are able to obtain affordable, high-quality health care for their more than 80,000 employees and dependents.

This legislation seeks to build on successful local initiatives, such as the Alliance, that help businesses to join together to increase access to affordable and high-quality health care.

The Promoting Health Care Purchasing Cooperatives Act would authorize grants to groups of businesses so that they could form group-purchasing cooperatives to obtain enhanced benefits, reduce health care rates, and improve quality.

This legislation offers two separate grant programs to help different types of businesses pool their resources and bargaining power. Both programs would aid businesses to form cooperatives. The first program would help large businesses that sponsor their own health plans, while the second program would help small businesses that purchase their health insurance.

My bill would enable larger businesses to form cost-effective cooperatives that could offer high-quality health care through several ways. First, they could obtain health services through pooled purchasing from physicians, hospitals, home health agencies, and others. By pooling their experience and interests, employers involved in a coalition could better address essential issues, such as rising health insurance rates and the lack of comparable health care quality data. They would be able to share information regarding the quality of these services and to partner with these health care providers to meet the needs of their employees.

For smaller businesses that purchase their health insurance, the formation of cooperatives would allow them to buy health insurance at lower prices through pooled purchasing. Also, the communication within these cooperatives would provide employees of small businesses with better information about the health care options that are available to them. Finally, coalitions would serve to promote quality improvements by facilitating partnerships between their group and the health care providers.

By working together, the group could develop better insurance plans and negotiate better rates.

This legislation also tries to alleviate the burden that our Nation's farmers face when trying to purchase health care for themselves, their families, and their employees. Because the health insurance industry looks upon farming as a high-risk profession, many farmers are priced out of, or simply not offered, health insurance. By helping farmers join cooperatives to purchase health insurance, we will help increase their health insurance options.

Past health purchasing pool initiatives have focused only on cost and have tried to be all things for all people. My legislation creates an incentive to join the pools by giving grants to a group of similar businesses to form group-purchasing cooperatives. The pools are also given flexibility to find innovative ways to lower costs, such as enhancing benefits—for example, more preventive care—and improving quality. Finally, the cooperative structure is a proven model, which creates an incentive for businesses to remain in the pool because they will be invested in the organization.

We must reform health care in America and give employers and employees more options. This legislation, by providing for the formation of cost-effective coalitions that will also improve the quality of care, contributes to this essential reform process. I urge my colleagues to join me in supporting this proposal to improve the quality and costs of health care.

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

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

S. 1165

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Promoting Health Care Purchasing Cooperatives Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress makes the following findings:

(1) Health care spending in the United States has reached 16.2 percent of the Gross Domestic Product of the United States, yet over 46,000,000 people remain uninsured.

(2) After nearly a decade of manageable increases in commercial insurance premiums, many employers are now faced with consecutive years of double digit premium increases.

(3) Purchasing cooperatives owned by participating businesses are a proven method of achieving the bargaining power necessary to manage the cost and quality of employer-sponsored health plans and other employee benefits.

(4) The Employer Health Care Alliance Cooperative has provided its members with health care purchasing power through provider contracting, data collection, activities to enhance quality improvements in the health care community, and activities to promote employee health care consumerism.

(5) According to the National Business Coalition on Health, there are nearly 60 employer-led coalitions across the United States that collectively purchase health care, proactively challenge high costs and the inefficient delivery of health care, and share information on quality. These coalitions represent more than 7,000 employers, and approximately 25,000,000 employees and their dependents.

(b) PURPOSE.—It is the purpose of this Act to build off of successful local employer-led health insurance initiatives by improving the value of their employees' health care.

SEC. 3. GRANTS TO SELF INSURED BUSINESSES TO FORM HEALTH CARE COOPERATIVES.

(a) AUTHORIZATION.—The Secretary of Health and Human Services (in this Act referred to as the ''Secretary''), acting through the Director of the Agency for Healthcare Research and Quality, is authorized to award grants to eligible groups that meet the criteria described in subsection (d), for the development of health care purchasing cooperatives. Such grants may be used to provide support for the professional staff of such cooperatives, and to obtain contracted services for planning, development, and implementation activities for establishing such health care purchasing cooperatives.

(b) ELIGIBLE GROUP DEFINED.—

(1) IN GENERAL.—In this section, the term ''eligible group'' means a consortium of 2 or more self-insured employers, including agricultural producers, each of which are responsible for their own health insurance risk pool with respect to their employees.

(2) NO TRANSFER OF RISK.—Individual employers who are members of an eligible group may not transfer insurance risk to such group.

(c) APPLICATION.—To be eligible to receive a grant under this section, an eligible group shall submit to the Secretary an application

at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) CRITERIA.—

(1) FEASIBILITY STUDY GRANTS.—

(A) IN GENERAL.—An eligible group may submit an application under subsection (c) for a grant to conduct a feasibility study concerning the establishment of a health insurance purchasing cooperative. The Secretary shall approve applications submitted under the preceding sentence if the study will consider the criteria described in paragraph (2).

(B) REPORT.—After the completion of a feasibility study under a grant under this section, an eligible group shall submit to the Secretary a report describing the results of such study.

(2) GRANT CRITERIA.—The criteria described in this paragraph include the following with respect to the eligible group involved:

(A) The ability of the group to effectively pool the health care purchasing power of employers.

(B) The ability of the group to provide data to employers to enable such employers to make data-based decisions regarding their health plans.

(C) The ability of the group to drive quality improvement in the health care community.

(D) The ability of the group to promote health care consumerism through employee education, self-care, and comparative provider performance information.

(E) The ability of the group to meet any other criteria determined appropriate by the Secretary.

(e) COOPERATIVE GRANTS.—After the submission of a report by an eligible group under subsection (d)(1)(B), the Secretary shall determine whether to award the group a grant for the establishment of a cooperative under subsection (a). In making a determination under the preceding sentence, the Secretary shall consider the criteria described in subsection (d)(2) with respect to the group.

(f) COOPERATIVES.—

(1) IN GENERAL.—An eligible group awarded a grant under subsection (a) shall establish or expand a health insurance purchasing cooperative that shall—

(A) be a nonprofit organization;

(B) be wholly owned, and democratically governed by its member-employers;

(C) exist solely to serve the membership base;

(D) be governed by a board of directors that is democratically elected by the cooperative membership using a 1-member, 1-vote standard; and

(E) accept any new member in accordance with specific criteria, including a limitation on the number of members, determined by the Secretary.

(2) AUTHORIZED COOPERATIVE ACTIVITIES.—A cooperative established under paragraph (1) shall—

(A) assist the members of the cooperative in pooling their health care insurance purchasing power;

(B) provide data to improve the ability of the members of the cooperative to make data-based decisions regarding their health plans;

(C) conduct activities to enhance quality improvement in the health care community;

(D) work to promote health care consumerism through employee education, self-care, and comparative provider performance information; and

(E) conduct any other activities determined appropriate by the Secretary.

(g) REVIEW.—

(1) IN GENERAL.—Not later than 1 year after the date on which grants are awarded under this section, and every 2 years thereafter, the Secretary shall study the programs funded under the grants and submit to the appropriate committees of Congress a report on the progress of such programs in improving the access of employees to quality, affordable health insurance.

(2) SLIDING SCALE FUNDING.—The Secretary shall use the information included in the report submitted under paragraph (1) to establish a schedule for scaling back payments under this section with the goal of ensuring that programs funded with grants under this section are self sufficient within 10 years.

SEC. 4. GRANTS TO SMALL BUSINESSES TO FORM HEALTH CARE COOPERATIVES.

The Secretary shall carry out a grant program that is identical to the grant program provided for in section 3, except that an eligible group for purposes of a grant under this section shall be a consortium of 2 or more employers, including agricultural producers, each of which—

(1) have 99 employees or less; and

(2) are purchasers of health insurance (are not self-insured) for their employees.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

From the administrative funds provided to the Secretary for each fiscal year, the Secretary may use not to exceed a total of $60,000,000 for fiscal years 2009 through 2018 to carry out this Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 164—AMENDING SENATE RESOLUTION 400, 94TH CONGRESS, AND SENATE RESOLUTION 445, 108TH CONGRESS, TO IMPROVE CONGRESSIONAL OVERSIGHT OF THE INTELLIGENCE ACTIVITIES OF THE UNITED STATES, TO PROVIDE A STRONG, STABLE, AND CAPABLE CONGRESSIONAL COMMITTEE STRUCTURE TO PROVIDE THE INTELLIGENCE COMMUNITY APPROPRIATE OVERSIGHT, SUPPORT, AND LEADERSHIP, AND TO IMPLEMENT A KEY RECOMMENDATION OF THE NATIONAL COMMISSION ON TERRORIST ATTACKS UPON THE UNITED STATES

Mr. FEINGOLD (for himself, Mr. BURR, Mr. BAYH, Ms. SNOWE, and Mr. MCCAIN) submitted the following resolution; which was referred to the Committee on Rules and Administration:

S. RES. 164

Whereas the National Commission on Terrorist Attacks Upon the United States (hereinafter referred to as the ''9/11 Commission'') conducted a lengthy review of the facts and circumstances relating to the terrorist attacks of September 11, 2001, including those relating to the intelligence community, law enforcement agencies, and the role of congressional oversight and resource allocation;

Whereas in its final report, the 9/11 Commission found that congressional oversight of the intelligence activities of the United States is dysfunctional;

Whereas in its final report, the 9/11 Commission further found that under the rules of the Senate and the House of Representatives in effect at the time the report was completed, the committees of Congress charged with oversight of the intelligence activities lacked the power, influence, and sustained capability to meet the daunting challenges faced by the intelligence community of the United States;

Whereas in its final report, the 9/11 Commission further found that as long as such oversight is governed by such rules of the Senate and the House of Representatives, the people of the United States will not get the security they want and need;

Whereas in its final report, the 9/11 Commission further found that a strong, stable, and capable congressional committee structure is needed to give the intelligence community of the United States appropriate oversight, support, and leadership;

Whereas in its final report, the 9/11 Commission further found that the reforms recommended by the 9/11 Commission in its final report will not succeed if congressional oversight of the intelligence community in the United States is not changed;

Whereas in its final report, the 9/11 Commission recommended structural changes to Congress to improve the oversight of intelligence activities;

Whereas in its final report, the 9/11 Commission further recommended that the authorizing authorities and appropriating authorities with respect to intelligence activities in each house of Congress be combined into a single committee in each house of Congress;

Whereas Congress has enacted some of the recommendations made by the 9/11 Commission and is considering implementing additional recommendations of the 9/11 Commission; and

Whereas the Senate adopted Senate Resolution 445 in the 108th Congress to address some of the intelligence oversight recommendations of the 9/11 Commission by abolishing term limits for the members of the Select Committee on Intelligence, clarifying jurisdiction for intelligence-related nominations, and streamlining procedures for the referral of intelligence-related legislation, but other aspects of the 9/11 Commission recommendations regarding intelligence oversight have not been implemented: Now, therefore, be it

Resolved,

SECTION 1. PURPOSES.

The purposes of this resolution are—

(1) to improve congressional oversight of the intelligence activities of the United States;

(2) to provide a strong, stable, and capable congressional committee structure to provide the intelligence community appropriate oversight, support, and leadership;

(3) to implement a key recommendation of the National Commission on Terrorist Attacks Upon the United States (the ''9/11 Commission'') that structural changes be made to Congress to improve the oversight of intelligence activities; and

(4) to provide vigilant legislative oversight over the intelligence activities of the United States to ensure that such activities are in conformity with the Constitution and laws of the United States.

SEC. 2. INTELLIGENCE OVERSIGHT.

(a) AUTHORITY OF THE SELECT COMMITTEE ON INTELLIGENCE.—Paragraph (5) of section 3(a) of Senate Resolution 400, agreed to May 19, 1976 (94th Congress), is amended in that matter preceding subparagraph (A) by striking the comma following ''authorizations for appropriations'' and inserting ''and appropriations,''.

(b) ABOLISHMENT OF THE SUBCOMMITTEE ON INTELLIGENCE.—Senate Resolution 445, agreed to October 9, 2004, (108th Congress), is amended by striking section 402.

Mr. FEINGOLD. Mr. President, I am introducing today, along with Senators BURR, BAYH, SNOWE and MCCAIN, a resolution that will implement a key recommendation of the 9/11 Commission—