may access to find out about state-specific information regarding advance directives and end-of-life planning decisions.

This legislation will allow eligible beneficiaries and their family caregivers to receive the information they need about advance directive and other end-of-life planning tools directly from their physicians. In addition, hospitals, skilled nursing facilities, home health agencies, and hospice programs will be required to provide the opportunity to discuss the general course of treatment expected, the likely impact on the length of life and function, and the procedures they should use to secure help if an unexpected situation arises. Such services will not only help improve quality of life, but will also help to reduce the stigma and fear of facing end-of-life issues in general.

The Senior Navigation and Planning Act would further protect the rights of individuals by requiring providers to honor written medical orders as a condition of payment. The bill would also provide incentives for hospice and palliative care accreditation and certification by providing bonus payments for those facilities with programs in place and a payment cut for facilities that do not have an accredited palliative program in place by 2020.

Beneficiaries with Alzheimer's disease and related dementias place heavy demands on the health care system. Because of the unique nature of their disease, individuals with cognitive impairment must rely on family caregivers and others to identify and obtain the right mix of services and supports to maintain their health and to live in the community as long as possible. This legislation would take the much-needed step of creating an Office of Medicare/Medicaid Integration to align program policies. The Office would simplify dual eligible access to Medicare and Medicaid program benefits and services; improve care continuity and ensure safe and effective care transitions; eliminate cost shifting between programs and among related care providers; eliminate regulatory conflicts; and improve total cost and quality.

Faith-based organizations often play a key role in end-of-life decision-making and planning for those with terminal illnesses. The Senior Navigation and Planning Act would empower the Secretary to create web-based materials as well as to establish end-of-life home-based service, training and education grants specifically for faith-based organizations. For individuals with end stage Alzheimer's disease and related dementias and their family caregivers in particular, faith-based services, training and support can make a world of difference in an otherwise isolating situation.

AFA is the face of care for individuals and their families who are affected by Alzheimer's disease and related dementias. We are proud to support the Senior Navigation and Planning Act and we look forward to working with you to advance this important legislation. If you have any further questions, please feel free to contact me, or have your staff contact Sue Peschin, AFA vice president of public policy.

Sincerely,

ERIC J. HALL,
President and Chief Executive Officer.

UNITEDHEALTH GROUP,
PENNSYLVANIA AVENUE, NW.,
Washington DC, June 11, 2009.

Hon. MARK WARNER,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR WARNER: I am writing to express UnitedHealth Group's strong support for your legislation, the Senior Navigation and Planning Act of 2009, which better equips seniors with the necessary tools, information and support needed to make informed medical decisions and ensure they receive the highest quality care.

Your legislation will fundamentally transform the way terminally ill patients and their families navigate the difficult decisions encountered at the end-of-life. We understand that when the elderly and their families are provided with relevant information and resources about care options such as hospice, palliative care, and the use of advanced directives, they are able to make more informed and personally appropriate decisions. By combining the best practices found in the public and private sectors, this legislation will go a long way in ensuring that patients facing the end-of-life are provided—through shared decision making with their physicians and caregivers—the most appropriate and sensitive care. UnitedHealth Group strongly supports patient-centered care, support services and planning tools for those with advanced illnesses. We applaud your focus on this important issue within the health reform debate.

UnitedHealth Group has a strong commitment to patient-centered end-of-life care, as demonstrated by the following programs and options that we offer to both Medicare beneficiaries and commercially-insured people:

Evercare Hospice and Palliative Care which operates in ten states and serves more than 1,200 people a day for their end-of-life needs.

The Advanced Illness Care Model which is offered through our Medicare Advantage and Special Needs Plans. This model provides coordinated care for patients with advanced illnesses and supports education for patients and their families regarding their clinical condition and the management of quality of life treatment issues in the last twelve months of life.

The Evercare Institutional Special Needs Plans (SNPs), which are specialized health plans that deploy nurse practitioners in nursing homes to assist in coordination of care and other planning services.

The UnitedHealth Care Hospice benefit which is an industry leader in the comprehensiveness of its plan offerings.

As a result of this accumulated experience, we understand that providing access to early and comprehensive hospice and palliative care services results in an increase in the quality of life for patients and reduction in futile and duplicative clinical interventions.

In conclusion, we are especially encouraged that your bill:

Creates a transitional care benefit to increase access to palliative care;

Establishes a national education campaign and clearinghouse providing advanced care planning resources;

Assures portability of advanced directives across states;

Creates incentives for hospitals and physicians to get accredited and certified in hospice and palliative care; and

Increases integration and coordination between the Medicare and Medicaid programs.

Thank you for your strong leadership in the U.S. Senate on this issue of critical importance to the entire health care system. We look forward to working with you to advance the Senior Navigation and Planning Act of 2009 and on other areas to strengthen our health care system.

Sincerely,

REED V. TUCKSON, MD,
Executive Vice President and Chief of Medical Affairs.

AETNA,
FARMINGTON AVENUE,
Hartford, CT, June 15, 2009.

Hon. MARK R. WARNER,
U.S. Senate,
Washington, DC.

DEAR SENATOR WARNER: Aetna is pleased to support the Senior Navigation and Planning Act of 2009. This legislation will strengthen the quality of counseling, support services, and care management for patients and families coping with life-limiting illnesses. We commend you for your leadership on these critical issues.

Aetna, itself, has been a leader in advocating for compassionate care in the face of life-threatening illness. In April 2004, Aetna announced a comprehensive program of case management support and expanded benefits to help Aetna members and their families cope more effectively with the complex medical and emotional issues associated with the end of life. In an innovative move, Aetna provided coverage for hospice benefits while allowing members to continue with curative care, and to do so with a life expectancy of twelve months instead of the six months Medicare allows. Aetna also pioneered a comprehensive program of case management provided by nurses trained in advance illness and in coordinating care in a manner that respects ethnic and cultural traditions.

Member reaction to Aetna's Compassionate Care Program has been gratifying. Ninety-six percent of participants' caregivers said they believed the member's needs for pain management and symptom relief were met in the final months of life. Sixty-three percent of program members accessed hospice, a significant increase over traditional Medicare.

In the pursuit of curative care, we too often fail to engage patients and loved ones in discussions of additional options for dealing with advanced illness and to support them in their choices. This legislation will help change that by facilitating the ability of patients and families to make informed decisions at times of stress and vulnerability. Aetna supports this legislation, and hopes to collaborate in the realization of its goals. We look forward to working with you and your Congressional colleagues to advance the quality of health care for all Americans.

Sincerely,

LONNY REISMAN, MD,
Chief Medical Officer.
RANDALL KRAKAUER, MD,
Head of Medicare Medical Management.

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

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

JUDGE SOTOMAYOR HEARINGS

Mr. MCCONNELL. Mr. President, it was less than 3 weeks ago that the President announced his intentions to nominate Judge Sonia Sotomayor to the Supreme Court. In announcing her nomination, the White House made much of the fact that the judge had the

lengthiest judicial record in recent memory. Last week, in a departure from past practice, the Democratic leadership of the Judiciary Committee unilaterally scheduled her hearing without even notifying the ranking member. Because of this unwise and unfair approach, Judge Sotomayor's hearing will begin just 3 weeks from today. As I understand it, her questionnaire is still incomplete. Among other deficiencies, she has not provided materials from 17 cases she handled as a prosecutor, nor has she provided materials from any appellate cases she handled, and she has not provided materials from over 100 speeches she has given.

During the Roberts and Alito hearings, our Democratic friends repeatedly told us it was more important to do it right than to do it quick. Now that there is a Democratic President, it appears the attitude is to just do it. They want the shortest confirmation process in recent memory for a nominee with the longest judicial record in recent memory. There is clearly a double standard at play here—one that undermines our ability to fulfill one of the Senate's most important and solemn responsibilities.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, as the national discussion over health care intensifies, one thing is already clear: Both Republicans and Democrats agree health care is in serious need of reform. The only thing that remains to be seen is what kind of reform we will deliver. Americans are increasingly worried about what they are hearing from Washington.

Americans want lower costs, and they want the freedom to choose their own doctors and their own care. What they do not want is a Washington takeover of health care along the lines of what we have already seen with banks, insurance companies, and the auto industry. Americans don't want a government-run system that puts bureaucrats between patients and doctors. They certainly don't want the kind of government boards that exist in places such as New Zealand and Great Britain that deny, delay, and ration treatments that are currently available to Americans.

Americans want change, but they do not want changes that will make existing programs worse. That is exactly what a government-run system would do.

Unfortunately, the notion of a government-run plan has been gaining steam. Over the past couple weeks, one Democratic leader after another has insisted that it be included as a part of any reform. The reaction to this should tell us something.

Among those who have begun to mobilize in opposition to America's plans are America's doctors who warn it would limit access to care and could lead to nearly 70 percent of Americans being kicked off the health plans they currently have.

The U.S. Chamber of Commerce, which represents about 3 million businesses in this country, has warned that the creation of a government plan would lead to a government-run health care system. The CEO of the renowned Mayo Clinic warned that some of the best providers could go out of business. The National Federation of Independent Businesses, one of the Nation's leading associations of small businesses, has also expressed its concerns about a government-run plan.

Americans don't want the kind of government-run system that some in Washington have proposed. They do not want politicians to use the real problems we have in our health care system as an excuse to tear down the whole thing, take away everything that is good about it, and replace it with something worse. They want practical solutions to specific problems, and that is what the rest of us are proposing.

Here are some commonsense proposals: We all agree health care in this country is too expensive. Americans don't think basic procedures should break the bank, and American families shouldn't have to worry about going bankrupt if a family member becomes ill.

But government-run health care will only make matters worse. If our experience with Medicare shows us anything, it is that the government health plans are not—I repeat are not—cost effective.

Over the weekend, the administration proposed making cuts to Medicare as a way of defraying the cost of a new government plan. That is exactly the wrong approach. America's seniors expect Congress to stabilize Medicare so it continues to serve their needs, not drain its resources to pay for another, even bigger government plan. Changes to Medicare should be used to make Medicare solvent for seniors today and for those who are paying into it and who will rely on the system tomorrow, not to build a brandnew government plan on top of one that is already on an unsustainable course. If we want to cut costs and rein in debt, then extending a Medicare-like system to everyone in America is exactly the wrong prescription. We need to make Medicare itself solvent and find ways to improve the current health care system.

One way to do that is to implement reforms that we know will save money. We could start with illness prevention programs that encourage people to quit smoking and to control their weight. It is no mystery that smoking and obesity are leading causes of the kinds of chronic diseases that are driving up health care costs. And finding ways to reduce these illnesses would also reduce costs. We should allow employers to create incentives for workers to adopt healthier lifestyles.

We should also encourage the same kind of robust competition in the health insurance market that has worked so well in the Medicare prescription drug benefit, Part D. We can enact long-overdue reforms to our Nation's medical liability laws. For too long, the threat of frivolous lawsuits has caused insurance premiums for doctors to skyrocket. Doctors then pass these higher costs on to patients, driving up the cost of care. Well, most people think health care dollars ought to be spent on health care, not insurance premiums. Yet doctors all across America are not only passing along the costs of higher and higher premiums, they are also ordering expensive and unnecessary tests and procedures to protect themselves against lawsuits.

One study suggests that roughly 9 out of 10 U.S. doctors in high-risk specialties practice some form of defensive medicine such as this—and the cost to patients is massive. Some doctors simply shut their practices or discontinue services as a result of these pressures. Patients such as Rashelle Perryman of Crittenden County Hospital are the ones who lose out. Rashelle's first two babies were born in Crittenden County Hospital, about 10 minutes from her home. But her third child had to be delivered about 40 miles away because rising malpractice rates caused doctors at Crittenden County Hospital to stop delivering babies altogether.

This isn't an isolated problem, and it is not just obstetricians. According to a report by the Kentucky Institute of Medicine, Kentucky is nearly 2,300 doctors short of the national average—a shortage that could be reduced, in part, by reforming medical malpractice laws.

Comprehensive health care reforms are long overdue—reforms that lower cost and increase access to care. But a government-run plan isn't the way to do it. There are other solutions that address our problems without undermining our strengths.

Over the past few weeks, I have warned about the dangers of government-run health care by pointing to the problems this kind of government-run system has created in places such as Britain, Canada, and New Zealand. These countries are living proof that when the government is in charge, health care is denied, delayed, and rationed. As I have noted, the main culprits in every case are the government boards that decide what procedures and medicines patients can and cannot have.

I have discussed how Britain's government board has denied care to cancer patients because the treatments were too expensive. In one case, bureaucrats in Britain refused to prescribe cancer drugs that were proven to extend the lives of patients because they cost too much. The government board explained it this way:

> Although these treatments are clinically effective, regrettably the cost . . . is such that they are not a cost effective use of . . . resources.

I have also discussed how the government-run health care system in Canada