LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

NATIONAL HISTORICALLY BLACK COLLEGES AND UNIVERSITIES WEEK

Mr. BENNET. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 269, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 269) designating the week beginning September 19, 2011, as ''National Historically Black Colleges and Universities Week.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. BENNET. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

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

The resolution (S. Res. 269) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 269

Whereas there are 105 historically Black colleges and universities in the United States;

Whereas historically Black colleges and universities provide the quality education essential to full participation in a complex, highly technological society;

Whereas historically Black colleges and universities have a rich heritage and have played a prominent role in the history of the United States;

Whereas historically Black colleges and universities allow talented and diverse students, many of whom represent underserved populations, to attain their full potential through higher education; and

Whereas the achievements and goals of historically Black colleges and universities are deserving of national recognition: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week beginning September 19, 2011, as ''National Historically Black Colleges and Universities Week''; and

(2) calls on the people of the United States and interested groups to observe the week with appropriate ceremonies, activities, and programs to demonstrate support for historically Black colleges and universities in the United States.

MEASURE READ THE FIRST TIME—H.R. 2587

Mr. BENNET. Mr. President, I understand there is a bill at the desk, and I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill for the first time.

The assistant legislative clerk read as follows:

A bill (H.R. 2587) to prohibit the National Labor Relations Board from ordering any employer to close, relocate, or transfer employment under any circumstance.

Mr. BENNET. I now ask for a second reading, and in order to place the bill on the calendar under the provisions of rule XIV, I object to my own request.

The PRESIDING OFFICER. Objection is heard. The bill will have its second reading on the next legislative day.

ORDERS FOR FRIDAY, SEPTEMBER 16, 2011

Mr. BENNET. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. on Friday, September 16; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day; that following any leader remarks, the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

PROGRAM

Mr. BENNET. Mr. President, there will be no rollcall votes on Friday. The next rollcall vote will be Monday, September 19, at 5:30 p.m.

ORDER FOR ADJOURNMENT

Mr. BENNET. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent it adjourn under the previous order, following the remarks of Senator WHITEHOUSE.

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

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

COSTS OF HEALTH CARE

Mr. WHITEHOUSE. Mr. President, we all traveled over to the House Chamber a few days ago to hear President Obama present his jobs plan, a jobs plan for which I intend to support and fight. But during the course of that speech, we also heard the President indicate that he was going to come and make some recommendations to the Senate and to the House regarding our debt and deficit strategy.

I come to the floor today to urge the White House, in dealing with our debt and our deficit issues, to pursue a strategy for cost reduction in our health care system that does not rely on harmful cuts to our seniors' Medicare benefits. I cannot tell you how important this is in Rhode Island where we have a significant senior population. Many of our seniors are low income. The average Social Security benefit is around $13,000 to $14,000.

Some of the ideas that have been floated in this body—more than just floated; they have actually passed the Congress, the House of Representatives—would be devastating to Rhode Island seniors: an end to Medicare in 10 years; $6,000 in increased costs to each senior, on average, per year, hidden in what the Republicans like to call their cut, cap and balance plan, with an even worse attack on Medicare and on Medicare beneficiaries than was in the House budget that passed, which was a bad enough attack on its own. That simply is more than seniors in Rhode Island can manage. It is not fair; it is not right. And, most importantly it is not necessary.

I do concede that rising health care spending has placed a lot of stress on our national budget. In the joint session of Congress in September 2009, President Obama himself said: Put simply, our health care problem is our deficit problem. Nothing else even comes close.

If you go to the other side of the political spectrum and to the other Chamber of Congress, Congressman RYAN said: Our debt and deficit problem is, at its core, a health care problem. I agree with that. We need to address it. The question is how.

The fundamental fact that so many of our colleagues overlook in their urgency to attack Medicare—a program that Republicans have been against from its very founding and that the renewed tea party assault on Medicare has revived—has misled the debate, because the cost problem in Medicare is not a problem that is unique to Medicare. Wherever you look in the American health care system, costs are exploding. They are going up in Medicare probably at a lower rate than other quadrants of the health care sector, but they are going up. They are going up in Medicaid. States are having trouble dealing with that burden. They are going up in TRICARE and in veterans' care. Indeed, Secretary Gates said: Health care costs are eating the Defense Department alive. Eating the Defense Department alive, health care costs are. And if you are in private insurance, whether it is Kaiser or United or Blue Cross, pick your insurer, the costs are going up dramatically. Our own hospitals in Rhode Island, which provide health care, are watching their health care costs accelerate at significant rates far above a multiple of our rate of inflation.

This problem of rising health care costs is creating real strain. It is not just creating strain on the Federal budget—granted, it is creating strain in the Federal budget—but it is also creating incredible stress on seniors, on small business owners who can't afford health insurance for themselves, or have to whittle away at the health insurance their employees have in order to keep it affordable, or have to give it up entirely as they face the stresses of this economic downturn.

As the Presiding Officer, the senior Senator from Colorado, knows because

his, like Rhode Island, is a small business State. When you are a small business, your employees are pretty darned close to family. When you have to whittle away at their health care benefits, when you have to whittle away at what they get, when you have to raise their costs, that is a hard decision for that small business owner/manager to make.

It is tough on American families. It is tough on big businesses. It is tough on American big export companies. Our automobile industry, the tractor manufacturers, the road building equipment manufacturers, the folks who build big American products that we export overseas, we build enormous amounts of health care costs into those products. It has been estimated that nearly $2,000 in health care costs goes into an American car. Well, the foreign car that competes in the international market with that American car comes out of a national health care system. So that health care cost isn't in the cost structure of the company that makes the car. And because they collected most of their taxes through a value-added tax, it doesn't even come in through the tax system, because the export products get out of those companies and into the international market without a tax burden. So there are our products, trying to compete overseas, with this weight of our health care system cost on them and it helps make America uncompetitive. So it is not just Medicare. It is everywhere in the American health care system. It is systemwide.

A couple of years back, when we were first discussing this issue and the White House held a couple of health care conferences, I was fortunate to be invited to those conferences. The President used a metaphor in discussing where we were in health care in those discussions. He used the discussion of us being headed for a cliff. If we didn't do something about our health care costs as a country, we were headed for a cliff.

Well, nothing has changed. We are still headed for that cliff, and the solution we have to find is to take the bus that we are all on and turn it before we get to the cliff.

It is not an adequate solution to simply throw seniors off the bus in order to lighten the Medicare cost load without doing what we need to do to change the direction of the American health care system to alleviate this cross-system, this economywide burden.

Fortunately, we gave President Obama tools to do this in the Affordable Care Act. We fought about all sorts of elements in the Affordable Care Act. We fought about the public option. We fought about universal coverage. There were imaginary claims raised that there were death panels in the health care bill. It was considered to be socialized medicine, the same phrase that was trotted out years ago to oppose Medicare. They brought that old stalwart phrase out again—totally false.

The only socialized medicine we have in this country is the kind we give our veterans, which is the very best quality care they are entitled to—what Bob Dole has said is the place we should look toward for health care reform. But that is a separate argument. But my point is there was a whole lot of phony controversy about that health care bill.

What was completely not discussed was that a huge chunk of that bill was dedicated to delivery system reform of the health care system, to turning the bus before we hit the cliff. There is a lot in there for the President to work with. There are literally dozens of programs and pilots to turn us in this new direction. I urge very strongly, as we address the government health care cost problem that we face, we look at it as a systemic problem, and we address it as a health care cost delivery system problem rather than pick out seniors, throw them off the bus, and keep it careening toward the cliff without changing its underlying direction. That would be, in medical parlance, a misdiagnosis of the illness and a mistreatment of it as a result, and fundamentally malpractice. But that is the direction we are being led, and I am here to urge us that we go in a different direction.

There is a lot to be gained. America's health care system is provably, wildly inefficient. We burn more than 18 percent of America's gross domestic product on our health care system every year—18 percent. To put that into context, the next most inefficient industrialized competitor that we deal with internationally runs at around 12 percent of gross domestic product. So here we are, the United States of America—the most innovative, the most technologically developed country in the world, a country that prides itself on efficiency, on common sense, on making smart decisions—and what are we doing? We are 50 percent more inefficient than the most inefficient other industrialized country in the world.

One would think that we would not be the most inefficient. One would certainly think we would not be the most inefficient by a margin of 50 percent over the second most inefficient country in the world. It just does not make any sense, but that is how bad it is. That is a pretty strong measure of how laden with excess costs our national health care system is.

For all of that, we do not get better outcomes. I wouldn't mind spending 50 percent more than Switzerland or France or any other country if we got 50 percent better outcomes, if we lived 50 percent longer, if we were 50 percent healthier, if we had 50 percent better care, if we had 50 percent better maternal mortality in childbirth—but we do not. When we look at the measures of how we do for our people in the American health care system, we compare with countries such as Greece and Croatia. We are down in the thirties in the ranking if you look at most of the quality measures.

Incredibly overbloated expenditure and at best moderate performance are the two prevailing characteristics of our health care system. That means there is a lot of ground to be gained.

It has been quantified by President Obama's own Council of Economic Advisers who estimated $700 billion every year could be saved if we cleaned up the health care system and made it moderately efficient. We could save that $700 billion without harming the quality of care for Americans.

That seems like a big number, but actually the New England Healthcare Institute says that number is $850 billion a year. George Bush's Treasury Secretary, Secretary O'Neill, who knows a lot about this from his time as CEO of Alcoa and as the person leading the Pittsburgh Regional Health Initiative, combined with the Lewin Group, which is a very well regarded Washington institution that looks at health care issues and evaluates them, they both agree that the number is $1 trillion a year that we could save without harming the experience or quality of care for the American consumer.

We tried to throw pretty much everything we could at this problem in the Affordable Care Act. A consultant to the administration, MIT Professor Jonathan Gruber, said about the Affordable Care Act and its delivery system reform component:

> Everything is in here. I can't think of anything I would do that they are not doing in that bill.

We gave the administration literally everything they could want, everything they asked for. I had a group that met with me as we were designing the Affordable Care Act, people from unions, people from NGOs that work on health care issues, people from the business sector, people who are experts in this area—to say, What are we missing? What more could we put in to help get at this problem of excessive costs for moderate results?

By the time the bill came to the floor, this was the answer from my group: Nothing. We can't think of anything else. We tried. It is all in there. So I agreed with Professor Gruber's assessment.

What is the nature of what we did? It boils down to what I contend are five basic strategies. One is quality improvement. The quality of American medicine is not anywhere near as good as it should be. Anybody who was listening to me talk, who has had a loved one in their family seriously ill, ill for any length of time, or who has been seriously ill themselves, they know that from their own experience. They know of the lost records. They know of the confusion between multiple doctors who are treating them and not talking to them, maybe both prescribing medications that are contra-indicated with each other, but they don't know the other one is doing it. They know the experience of having to be your own navigator through this complex system. They know what a nightmare that

is. They know it. It is not a debatable proposition.

It also works out in some pretty identifiable data. Nearly one in every 20 hospitalized patients in the United States gets a hospital-acquired infection. A hospital-acquired infection should be a ''never'' event. If we apply the Pronovost principles and do things started in Michigan and are carried out around the country now, we can knock that down by about 90 percent, but still it is endemic.

Everybody knows somebody who has gone to a hospital for a procedure and came out with a hospital-acquired infection, often a life-threatening one. Just treating those infections costs about $2.5 billion a year. They are completely avoidable.

That is just one element of the health care system. If we got after the quality gaps in our health care system, the savings would be far greater. So there is a lot to be gained in quality. That is one of the five.

The second is prevention. We do not analyze and evaluate and implement prevention strategies very well as a country. We don't even evaluate effectively what prevention methods save enough money in the long run that we should just pay for them for everybody because it saves money to have people do this. We don't differentiate between what is probably a good idea for an individual to pay for and what is such a good idea and saves so much money that it should be part of the baseline of medical treatment that every American gets. It doesn't matter how sick they are, doesn't matter how old they are, doesn't matter how wealthy they are, doesn't matter where they live, they should be getting this prevention treatment because it saves all of us money.

We should be analyzing those things, proving them and putting that prevention strategy to work because the cheapest way to treat an illness is to prevent it in the first instance. The third is payment reform. We pay doctors more—the more they prescribe, the more tests they order, the more medications they order, the more procedures they direct, the more they get paid. It should come as no surprise that when you send that incentive out there into that particular marketplace, you get dramatic overuse, which has been quantified in study after study.

This bill, the Affordable Care Act, has pilots to start directing the payment for medical procedures and for medical care based on the outcomes so that its value is how well you get that dictates payment, not how much the doctor does to you. That will be a paradigm shift in health care. You have to get it right. It is not easy to do. It is going to take some doing, but it is vitally important. That is the third part.

The fourth is administrative simplification, in particular, administrative simplification in the area of the warfare that currently exists between health insurance companies and hospitals and doctors. Ask any hospital, ask any doctor what it is like dealing with the insurance companies, trying to get paid for the services they deliver. They will tell you it is torture.

The last time I was at the Cranston Community Health Center in Rhode Island, they told me half of their personnel are dedicated to trying to get paid. The other half do the health care work. Half of their personnel are dedicated to trying get paid. And they have a $200,000 a year contract with experts to try to help train the 50 percent of their personnel who are dedicated to trying to get paid in what the latest tricks are from the insurance industry so they can keep ahead of the game. Because it is an arm's race. Well, my guess is that about 10 percent of the health care dollar that goes through the insurance companies goes to delay and denial of payment. There is 10 cents right off the top, leaving only 90 cents for the rest of the health care equation.

The doctors and the hospitals have to fight back. They have to hire their own consultants and their own experts and their own billing companies. They are not as efficient. There are more of them. They are more spread out. It is not what they are expert at. It is harder for them to fight back. I think they pay more than 10 cents out of every dollar. You put the 2 together, that is 20 cents out of the health care dollar on the private insurance side that does not go to health care at all. It goes to fund the arms race between insurers and doctors over getting paid.

This year Health Affairs: Journal of Health Care Policy published a study that compared the administrative costs of physician practices in Ontario, Canada, and physician practices in the United States. It found if doctors in the United States could lower their administrative costs to match those of the Ontario physicians, the total savings would be approximately $27.6 billion a year. The Ontario doctors have administrative costs, but they have a single-payer system and it is pretty easy to deal with. The $27.6 billion is primarily fighting with the different insurance companies that all have different systems about claims and billing. There are big savings to be had by eliminating that unnecessary and expensive warfare that produces zero health care benefit to anybody.

The last piece, which is the structure for most of the rest of it, is a solid, strong health information technology infrastructure for this country. I can go to a bank anywhere in this country and I can take out my ATM card and access my checking account. I can find out what is in my savings account. I can do transactions. I can make deposits. However, if I step out of that ATM booth and get whacked by a taxicab and rushed to the emergency room, they have no idea what my health history is or what my health records are. We do not have a modern electronic health record in this country. We do not have modern electronic infrastructure in this country.

When I started arguing about this a few years ago, I can remember The Economist magazine publishing an article that said the health care industry in America was the worst industry for the deployment of information technology of all of the American industries except one. The only industry that was behind the health care industry and the deployment of information technology was the mining industry. We have improved, thanks to President Obama and this administration putting a big investment in this area, but we have a long way to go because we were way behind the curve.

Those five things—quality improvement, serious investment and prevention where it saves money, payment reform so that the system has incentive to provide value rather than volume, knocking down the administrative overhead that drapes over this system and weighs it down, and a robust health information technology infrastructure, those are the five keys and almost every single one of the programs I referred to that is in the Affordable Care Act fits one of those principles.

Why are we not doing this? Why is this not a bigger part of the debate if it is $700 billion to $1 trillion a year, if the result is better care for Americans, fewer medical errors, more prevented illness, less nonsense and unnecessary care from their doctors in chasing the payment model of volume, less fighting with the insurance company over trying to get paid and a health information record that is yours, that is private, that is secure, that goes with you wherever you are?

There was a fellow in Rhode Island whose daughter was taken ill. She had a pretty serious condition. She was taken to the emergency room in Rhode Island, and they realized that this was bad. They needed specialty care, specialty machinery and treatment, and they had to rush to the specialty hospital in Massachusetts that could do the work on her she needed to save her life. So off they went. When they got there, they discovered that they had not brought her paper health records with her. They had to redo all the testing. They had to start from scratch. Seconds counted as they fought for this woman's life. Thankfully it all turned out fine, but it put her life at risk and it cost a fortune to redo all the tests. It made her recovery harder because a lot of time was wasted. Are you kidding me, a paper health record? But that is where we are.

All of this is win-win. Where is the pressure to do it? Well, there is a problem, and the problem is that it is not the kind of change that CBO—the people who guide our budget decisions around here—can score. I asked Alan Simpson from the Simpson-Bowles budget group during one of our Budget Committee hearings if he believed that reducing health care costs through delivery system reform is an important

part of addressing our debt and deficit problem. And he answered: What you are saying is exactly right. It is not, unfortunately, scoreable. That is why it is not in our report.

I get it. It is not scoreable. It is not in the report. We should not overlook these factors as we make these decisions on behalf of the American people because even if you cannot score how you get to that $700 billion in savings or if the New England Health Care Institute is right, that $850 billion, or if Bush Secretary O'Neill is right, that $1 trillion a year in savings using methods that improve both our experience and quality of care needs to be a priority even if it is not scoreable.

Tomorrow I will send a letter to the President, which the Presiding Officer has been good enough to sign, along with a broad array of my colleagues who have agreed to cosign, which reiterates the case I make here tonight. The letter urges the President's attention to the potential of delivery system reform rather than Medicare benefit cuts for seniors. It should be our first priority to fix that overloaded 50 percent more inefficient than the most inefficient country in the world system, the one with $700 billion or $850 billion or $1 trillion in annual savings that are possible. Fix that before you go to a senior who had no part in this, who cannot help but try to do their best, and say to them, we are taking away your benefit. That is not the way to proceed. That is the wrong way to proceed. It is morally wrong and it is wrong as a matter of policy.

Where I contend we are—and I will say this in closing—there is a movement and an industry emerging in the area of health care delivery system reform. It is strong in the private sector, whether we look at places such as Palmetto down the Carolina Coast; Geisinger in the Pennsylvania area; up in the Wisconsin area, Gundersen Lutheran; out toward Utah, the west, Inner Mountain; Mayo in Minnesota and Florida; or Kaiser, based in California. These are all major American health care delivery companies that have seen the potential delivery system reform. They are working hard to make it happen. They are committed to it, and they are getting results. We need to have their back. We need to support them as they do this.

But it is never going to be scorable because this is not a mathematical equation where we say: You are not getting this benefit. We are going to take away 20 percent of what you get. We are going to run it through the same nonsensical system that causes most of our cost problems and at the end we are going to say it is going to be 20 percent cheaper. It is easy to do the math that way, but it is a pretty cruel way, and it is lazy because we need to be in the middle fixing that piece.

But it is not arithmetically easy because where we are is like the early stages, I contend, of the airline industry—I should say of the flight industry. What did we know when the Wright Brothers first put their flying machine into the air at Kitty Hawk? We knew a curved surface sped through the air, generated lift. We knew a whirling air screw generated propulsion, and we knew that if you twisted the ends of the wings, you could control the direction. Those principles haven't changed.

I just got back from Afghanistan and Pakistan. We flew for 14 hours from the Arabian Peninsula back to Dulles Airport. That plane had movies on it. It had food on it. Everybody was comfortable. It had air-conditioning. We landed a plane that was the size of probably the average small town in America at the time the Wright Brothers were flying and everybody on it felt perfectly safe and comfortable. It came down a tube of electronic decision support for those pilots so they knew exactly what was going on every moment. If you went back to the Wright Brothers, you could not score in the actuarial sense the progress that would lead us in less than a century from a rickety wooden canvas, manned kite, puffing down the beach at Kitty Hawk, to these sleek, computer-guided, miraculous aircraft that fly us in comfort around the world today. You could not do it. But that didn't mean we shouldn't bet on it. That didn't mean we shouldn't pursue it. That didn't mean it wouldn't make a huge difference in the quality of mankind's life to be able to have that technological lead.

So that is where we are. These five principles are a little bit beyond the Kitty Hawk stage perhaps but not by much. If we invest and if we get behind this, the day will come, and it will come soon, when the quality of health care each one of us receives—we will look back and we will think, what we are getting now, that was canvas and wood sticks. That was primitive. We will have personalized electronic health care. Companies will emerge to create applications so whatever illness you have, the very best treatment will be downloaded so you know what you should be doing, when, and it will be adjusted for your blood type and family history and gender, if it is a factor that makes a difference, and for your body mass. Whatever it is that is relevant to you getting the best treatment as an individual, that is the kind of stuff that will be available. We will aggregate the data about what is effective, and people who have far more brilliance than I will plow through all the data about America's health care experience and they will start learning things about what works and what doesn't, what two things we didn't notice are connected. We will start to find those anomalies or those associations, and that will open a whole new era of discovery and treatment. Between those new applications that will guide in a personalized way health care for Americans, based on their own data and based on the best available information so your doctor is a little bit like that pilot landing the plane out of Dulles, making their own decisions, flying the plane directly but surrounded by that decision support that makes plane landings so safe—if your wheels aren't down, the alarms go off. If you get out of the glide slope, the alarms go off. If there are wind gusts on the field, the alarms go off. All that information and more is captured so the pilots can focus on flying the plane. That is the kind of support our doctors can have. That is the kind of support we can have. Those are American industries that will grow and emerge.

So we need to get behind this. I feel very strongly about this, as my colleagues can tell and as the four pages have had to wait and listen to me at this late hour can tell. But I say now it would be a shameful act on the part of the Congress of the United States if, with an opportunity like that in front of us, if with a compelling cost target, as we have from delivery system reform in front of us, and with the proven thesis that by getting there we actually improve the quality of care for people—we are not taking anything away; we are making their quality and experience of care better, which is a win-win-win. If we turn away from that win-win-win and instead take the easy, lazy way of throwing seniors off the bus and putting Medicare benefit cuts on them and let that bus just keep rocketing toward that cliff, that will be a moment that will merit the scorn of the American people and the shame of our own conscience because we will have done the wrong thing and we will have done it because it was the easy way out.

I urge the White House not to take that road and to instead redouble their efforts on delivery system reform, back Secretary Sebelius in what she is doing and Don Berwick in what he is doing and, most significantly, put a hard date and dollar metric out there so the world can evaluate how well the administration did. If this is as important as I think it is, if this is as important as the administration thinks it is by the work they have already dedicated to it, then they should be willing to set for themselves a date and dollar savings target to tell the country: By this date, we will save this many hundreds of billions of dollars a year through delivery system reform. If we don't, then it is murk, it is mush. There is no accountability to it. It is generally going in the right direction.

A young President many years ago had a similar opportunity. We were losing the space race to the Soviet Union. He could have said in his speech: I think it is time that we bent the curve of America's space program. I think it is time we bent the curve of America's space exploration. But he didn't. He said something much more specific. He said: Within a decade, the United States of America is going to put a man on the Moon and bring him home safely. If President John Fitzgerald

Kennedy had given that first speech, we would never have put a man on the Moon. The reason we put a man on the Moon is because when a President of the United States sets a hard target for the Government of the United States, that vast bureaucracy moves to achieve that purpose. If the President of the United States denies that vast bureaucracy, the clarity of that purpose does not give a specific measurable goal, and it makes that goal far less likely to achieve.

So not only do I ask the White House to turn away from Medicare benefit cuts and redouble their efforts on delivery system reform, I ask them to decide how much they are going to save, and by when, and let us know so we can evaluate their success in meeting that goal. I promise them every support in reaching that goal.

I thank the Presiding Officer for his patience and yield the floor.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 10 a.m. tomorrow.

Thereupon, the Senate, at 8:07 p.m., adjourned until Friday, September 16, 2011, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

THE JUDICIARY

RONALD LEE BUCH, OF VIRGINIA, TO BE A JUDGE OF THE UNITED STATES TAX COURT FOR A TERM OF FIFTEEN YEARS, VICE DAVID LARO, TERM EXPIRED.

DEPARTMENT OF THE TREASURY

ALASTAIR M. FITZPAYNE, OF MARYLAND, TO BE A DEPUTY UNDER SECRETARY OF THE TREASURY, VICE KIM N. WALLACE.

DEPARTMENT OF DEFENSE

BRAD CARSON, OF OKLAHOMA, TO BE GENERAL COUNSEL OF THE DEPARTMENT OF THE ARMY, VICE BENEDICT S. COHEN, RESIGNED.

THE JUDICIARY

KEVIN A. OHLSON, OF VIRGINIA, TO BE A JUDGE OF THE UNITED STATES COURT OF APPEALS FOR THE ARMED FORCES FOR THE TERM OF FIFTEEN YEARS TO EXPIRE ON THE DATE PRESCRIBED BY LAW, VICE ANDREW S. EFFRON, TERM EXPIRING.

FOREIGN SERVICE

THE FOLLOWING-NAMED CAREER MEMBERS OF THE SENIOR FOREIGN SERVICE OF THE DEPARTMENT OF STATE FOR PROMOTION INTO AND WITHIN THE SENIOR FOREIGN SERVICE TO THE CLASSES INDICATED:

CAREER MEMBERS OF THE SENIOR FOREIGN SERVICE OF THE UNITED STATES OF AMERICA, CLASS OF CAREER MINISTER:

JOHN ROSS BEYRLE, OF MICHIGAN
ROBERT O. BLAKE, OF MARYLAND
JEFFREY DAVID FELTMAN, OF OHIO
MARGARET SCOBEY, OF TENNESSEE
HARRY K. THOMAS, JR., OF NEW YORK

CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR:

CHARLES V. BARCLAY, OF CALIFORNIA
JOHN R. BASS II, OF NEW YORK
ROBERT STEPHEN BEECROFT, OF CALIFORNIA
RICHARD C. BEER, OF VIRGINIA
PHILIP JACKSON BREEDEN, OF CALIFORNIA
PETER MEIER BRENNAN, OF OREGON
SCOTT P. BULTROWICZ, OF OHIO
BEATRICE A. CAMP, OF VIRGINIA
JUDITH BETH CEFKIN, OF TEXAS
ANDREW GILMAN CHRITTON, OF TEXAS
PETER CLAUSSEN, OF FLORIDA
THOMAS FREDERICK DAUGHTON, OF NEW YORK
PANAKKAL DAVID, OF NEW YORK
JOSEPH ADAM ERELI, OF THE DISTRICT OF COLUMBIA
RODNEY ALLEN EVANS, OF VIRGINIA
PAUL MICHAEL FITZGERALD, OF VIRGINIA
THOMAS R. GENTON, OF NEW JERSEY
TATIANA CATHERINE GFOELLER-VOLKOFF, OF THE DISTRICT OF COLUMBIA
BRIAN L. GOLDBECK, OF NEVADA
DOUGLAS C. GREENE, OF VIRGINIA
DOUGLAS M. GRIFFITHS, OF TEXAS
FRANCISCA THOMAS HELMER, OF CALIFORNIA
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THOMAS PATRICK KELLY, OF CALIFORNIA
JAMES ALCORN KNIGHT, OF NEW YORK
JERRY P. LANIER, OF NORTH CAROLINA
BARBARA ANNE LEAF, OF VIRGINIA
FRANK JOSEPH LEDAHAWSKY, OF NEW JERSEY
EDWARD ALEX LEE, OF TEXAS
DAVID ERIK LINDWALL, OF TEXAS
MICHELLE RABAYDA LOGSDON, OF FLORIDA
SHARON E. LUDAN, OF VIRGINIA
ERIC H. MADISON, OF VIRGINIA
CHRISTOPHER J. MARUT, OF CONNECTICUT
ATHENA M. MOUNDALEXIS, OF TENNESSEE
DANIEL R. MUHM, OF WASHINGTON
RICHARD A. NICHOLAS, OF COLORADO
EDWIN RICHARD NOLAN, JR., OF VIRGINIA
GEETA PASI, OF NEW YORK
MARJORIE R. PHILLIPS, OF VIRGINIA
GEOFFREY R. PYATT, OF CALIFORNIA
PAMELA G. QUANRUD, OF VIRGINIA
MICHAEL A. RAYNOR, OF MARYLAND
FRANKIE ANNETTE REED, OF MARYLAND
NANCY C. ROLPH-O'DONNELL, OF VIRGINIA
ERIC SETH RUBIN, OF NEW YORK
RICHARD MILTON SANDERS, OF PENNSYLVANIA
DANIEL L. SHIELDS III, OF PENNSYLVANIA
SANDRA JEAN SHIPSHOCK, OF VIRGINIA
KAREN CLARK STANTON, OF VIRGINIA
MARK CHARLES STORELLA, OF MARYLAND
ALAINA TEPLITZ, OF THE DISTRICT OF COLUMBIA
HEATHER ANN TOWNSEND, OF THE DISTRICT OF COLUMBIA
HUGH FLOYD WILLIAMS, OF PENNSYLVANIA
SUSAN L. ZIADEH, OF WASHINGTON

THE FOLLOWING-NAMED CAREER MEMBERS OF THE FOREIGN SERVICE FOR PROMOTION INTO THE SENIOR FOREIGN SERVICE, AS INDICATED:

CAREER MEMBERS OF THE SENIOR FOREIGN SERVICE OF THE UNITED STATES OF AMERICA, CLASS OF COUNSELOR:

BRIAN C. AGGELER, OF THE DISTRICT OF COLUMBIA
ELIZABETH MOORE AUBIN, OF MARYLAND
COLOMBIA A. BARROSSE, OF VIRGINIA
GLORIA F. BERBENA, OF CALIFORNIA
PAUL SIDNEY BERG, OF NEW YORK
RENA BITTER, OF THE DISTRICT OF COLUMBIA
STEVEN CRAIG BONDY, OF VIRGINIA
PAUL A. BROWN, OF TEXAS
RUSSEL BROWN, OF MARYLAND
IAN G. BROWNLEE, OF MARYLAND
RANDALL C. BUDDEN, OF MICHIGAN
KATHRYN A. CABRAL, OF FLORIDA
ELLEN MARY CONWAY, OF MARYLAND
JOYCE EDITH CURRIE, OF VIRGINIA
JON F. DANILOWICZ, OF VIRGINIA
ELIZABETH W. DAVIS, OF CALIFORNIA
MICHAEL J. DODMAN, OF VIRGINIA
BRUCE E. DONAHUE, OF VIRGINIA
DALE B. EPPLER, OF WASHINGTON
MARTHA E. ESTELL, OF VIRGINIA
ANNETTE P. FEELEY, OF THE DISTRICT OF COLUMBIA
ROBERT S. GILCHRIST, OF FLORIDA
LINDA THOMPSON-TOPPING GONZALEZ, OF THE DISTRICT OF COLUMBIA
CANDY GREEN, OF CALIFORNIA
ALYSON LYNN GRUNDER, OF VIRGINIA
BONNIE S. GUTMAN, OF THE DISTRICT OF COLUMBIA
KATHERINE B. HADDA, OF NEW YORK
KRISTIN M. HAGERSTROM, OF LOUISIANA
HELEN H. HAHN, OF VIRGINIA
LISA KENNEDY HELLER, OF VIRGINIA
DAVID EDWARD HENIFIN, OF VIRGINIA
KATHLEEN M. HENNESSEY, OF NEW YORK
PATRICIA K. KABRA, OF THE DISTRICT OF COLUMBIA
EDWARD WESLEY KASKA, JR., OF VIRGINIA
KATHLEEN ANN KAVALEC, OF CALIFORNIA
ATUL KESHAP, OF VIRGINIA
MARC E. KNAPPER, OF CALIFORNIA
DAVID J. KOSTELANCIK, OF ILLINOIS
STEVEN HERBERT KRAFT, OF VIRGINIA
JOHN M. KUSCHNER, OF NEW HAMPSHIRE
KAMALA SHIRIN LAKHDHIR, OF CONNECTICUT
TIMOTHY LENDERKING, OF THE DISTRICT OF COLUMBIA
MARK A. LEONI, OF CALIFORNIA
MARK STEVEN MAYFIELD, OF TEXAS
PATRICIA SHEEHAN MCCARTHY, OF VIRGINIA
JOHN F. MCNAMARA, OF MARYLAND
WILLIAM R. MEARA, OF NEW YORK
STEPHANIE ANNE MILEY, OF VIRGINIA
RICHARD M. MILLS, JR., OF FLORIDA
PETER F. MULREAN, OF NEW YORK
MIREMBE NANTONGO, OF KANSAS
WILLIAM A. OSTICK, OF GEORGIA
NANCY BIKOFF PETTIT, OF VIRGINIA
JOAN POLASCHIK, OF VIRGINIA
EMILIA A. PUMA, OF VIRGINIA
RICHARD S. SACKS, OF VIRGINIA
JO ANN E. SCANDOLA, OF THE DISTRICT OF COLUMBIA
ANDREW J. SCHOFER, OF THE DISTRICT OF COLUMBIA
JEFFREY R. SEXTON, OF FLORIDA
GARY LEE SHEAFFER, OF VIRGINIA
ADNAN A. SIDDIQI, OF TEXAS
ANDREW D. SIEGEL, OF CALIFORNIA
LAWRENCE ROBERT SILVERMAN, OF VIRGINIA
TERESA FAYE STEWART, OF TENNESSEE
MARY E. TARNOWKA, OF CALIFORNIA
MARK TONER, OF MARYLAND
CONRAD ROBERT TRIBBLE, OF CALIFORNIA
KATHERINE VAN DE VATE, OF TENNESSEE
LEO F. VOYTKO, JR., OF VIRGINIA
MATTHEW ALAN WEILLER, OF NEW YORK
HOYT B. YEE, OF CALIFORNIA

CAREER MEMBERS OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, AND CONSULAR OFFICERS AND SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

JAMES B. ANGELL, OF CALIFORNIA
MICHAEL J. BARELA, OF VIRGINIA
MAURICE C. CROSSLAND, JR., OF PENNSYLVANIA
JAN MARIE FLATTUM-REIMERS, OF NORTH DAKOTA
MELISSA CLAIRE FOYNES, OF TEXAS
GLEN A. GERSHMAN, OF MARYLAND
PETER G. GIBBONS, OF VIRGINIA
BARRY L. HANEY, OF FLORIDA
PETER S. HARGRAVES, OF TEXAS
LEIGH ANN KIDD, OF VIRGINIA
ANDRIY R. KOROPECKYJ, OF MARYLAND
DOYLE R. LEE, OF FLORIDA
NIALL E. MEEHAN, OF VIRGINIA
EDWARD J. MIRON, OF NEW YORK
JOHN S. MORETTI, OF VIRGINIA
KURT E. OLSSON, OF VIRGINIA
LAWRENCE PAUL OSTROWSKI, OF FLORIDA
JOSEPH N. RAWLINGS, OF GEORGIA
JIM W. SCHNAIBLE, OF VIRGINIA
DANIEL J. WEBER, OF WASHINGTON

THE FOLLOWING-NAMED MEMBERS OF THE FOREIGN SERVICE OF THE DEPARTMENT OF COMMERCE TO BE CONSULAR OFFICERS AND SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

ROBERT DONOVAN, JR., OF THE DISTRICT OF COLUMBIA
PETER FOWLER, OF THE DISTRICT OF COLUMBIA
ALBERT KEYACK, OF VIRGINIA
BARBARA LAPINI, OF VIRGINIA
LINDA MINSKER, OF THE DISTRICT OF COLUMBIA
BRENDA VANHORN, OF VIRGINIA

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER TITLE 14, U.S.C, SECTION 271:

To be rear admiral (lower half)

CAPTAIN MARK E. BUTT
CAPTAIN LINDA L. FAGAN
CAPTAIN THOMAS W. JONES
CAPTAIN STEVEN D. POULIN
CAPTAIN JAMES E. RENDON
CAPTAIN JOSEPH A. SERVIDIO

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE GRADE INDICATED IN THE REGULAR ARMY NURSE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

KELLY A. CRICKS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE GRADE INDICATED IN THE REGULAR ARMY MEDICAL SERVICE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

DAMIAN G. MCCABE

THE FOLLOWING NAMED OFFICER IN THE GRADE INDICATED IN THE REGULAR ARMY UNDER TITLE 10, U.S.C., SECTION 531:

To be major

JOHN R. PENDERGRASS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

ROBERT D. BLACK
GEORGETTE GOONAN
TRUDY A. SALERNO

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

JAMES A. CHRISTENSEN
CHRISTOPHER J. DEMEULENAERE
FORD D. PAULSON
KATHLEEN A. WILLIAMS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

MATTHEW J. CONDE
RAYMOND FEELEY
MICHAEL E. GAFNEY
DANE S. HARDEN
GARY J. MCKAY
OWEN F. MUELLER
VICTOR M. PALOMARES

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

LEE A. ADAMS
ROXANNE M. ARNDT
BEVERLY A. BLAIR
PATRICIA M. BRIGHAM
NANCY A. CANTRELL