

ALLOCATION OF SPENDING AUTHORITY TO SENATE COMMITTEES OTHER THAN APPROPRIATIONS—Continued  
 (\$ in billions)

	2026	2026–2030	2026–2035
Outlays .....	0.001	0.005	0.005
Unassigned to Committee			
Budget Authority .....	–2,232.970	–12,417.589	–28,448.062
Outlays .....	–2,077.280	–12,266.015	–28,181.005
<b>TOTAL</b>			
Budget Authority .....	3,526.421	18,477.322	41,874.432
Outlays .....	3,578.166	18,180.571	40,955.990

Note: Includes entitlements funded in annual appropriations acts. Certain budgetary changes related to reconciliation legislation will be held in reserve pursuant to section 3001 of S. Con. Res. 33 until the consideration of such legislation.

BUDGET AGGREGATES

(\$ in billions)

	2026	2026–2030	2026–2035
Spending:			
Budget Authority .....	5,191.630	N.A.	N.A.
Outlays .....	5,465.225	N.A.	N.A.
Revenue:			
Outlays .....	4,242.825	23,139.567	51,341.472
Social Security Levels:			
Outlays .....	1,509.338	8,584.084	19,834.933
Revenue .....	1,350.445	7,303.693	16,121.509

Note: Aggregate figures here exclude spending designated as being for an emergency requirement or exempt from budget enforcement by statute. Budgetary changes related to reconciliation legislation will be held in reserve pursuant to section 3001 of S. Con. Res. 33 until the consideration of such legislation.

PAY-AS-YOU-GO SCORECARD FOR THE SENATE

(\$ in billions)

	Balances
Fiscal Year 2026 .....	0
Fiscal Years 2026–2030 .....	0
Fiscal Years 2026–2035 .....	0

U.S. GOVERNMENT ACCOUNTABILITY OFFICE OPINION LETTER

Mr. WYDEN. Mr. President, I ask unanimous consent that the following GAO opinion letter dated May 12, 2026, be printed in the RECORD.

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

DECISION

Matter of: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services—Applicability of the Congressional Review Act to Notice Implementing the Wasteful and Inappropriate Services Reduction (WISeR) Model.

File: B-337994.  
 Date: May 12, 2026.

DIGEST

On July 1, 2025, the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) issued a notice announcing the implementation of the Wasteful and Inappropriate Services Reduction (WISeR) Model, a new process to be used in six states to evaluate whether claims for certain medical items and services comply with Medicare requirements (WISeR Model Notice or Notice).

The Congressional Review Act (CRA) requires that before a rule can take effect, an agency must submit the rule to both the House of Representatives and the Senate, as well as the Comptroller General. CRA adopts the definition of a rule under the Administrative Procedure Act (APA) but excludes certain categories of rules from coverage. We conclude that the WISeR Model Notice is a rule for purposes of CRA because it meets the APA definition of a rule, and no CRA exception applies. Among other things, the WISeR Model Notice prescribes new requirements for Original Medicare providers in selected states by mandating prior authorization or pre-payment medical review of claims for certain services. Given the nature of the changes and because they could poten-

tially affect the determinations made on claims for the selected services, we conclude that the Notice substantially affects the rights and obligations of non-agency parties, specifically providers and beneficiaries of those services. Therefore, the Notice is a rule subject to CRA’s submission requirements.

DECISION

On July 1, 2025, the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) issued a notice announcing the implementation of the Wasteful and Inappropriate Services Reduction (WISeR) Model, a new process to be used in six states to evaluate whether claims for certain medical items and services comply with Medicare requirements. We received a request for a decision as to whether the implementation of the WISeR Model is a rule for purposes of the Congressional Review Act (CRA). As discussed below, we conclude that the WISeR Model Notice is a rule subject to CRA’s submission requirements.

Our practice when rendering decisions is to contact the relevant agencies to obtain factual information and their legal views on the subject of the request. Accordingly, we reached out to HHS on January 13, 2026. We received HHS’s response on February 20, 2026.

BACKGROUND

Original Medicare

Medicare consists of four distinct parts: Parts A, B, C, and D. Original Medicare—sometimes called Medicare Fee-for-Service (FFS)—includes Part A and Part B. Part A (Hospital Insurance) “helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.” Part B (Medical Insurance) helps cover a range of medical services and supplies, including physician, outpatient, and some home health care, durable medical equipment, and many preventive services. Medical providers and suppliers submit Part A and Part B claims for services and items to Medicare Administrative Contractors (MACs)—private health insurers that have specific geographic jurisdictions—which process and pay the claims.

CMS and MACs employ a variety of techniques to reduce fraud, waste, and abuse in Original Medicare. These include publishing “National and Local Coverage Determinations (NCDs and LCDs, respectively) describing the evidence-based requirements and limitations for Medicare coverage for specific medical services, procedures, or devices.” MACs also operate a medical review program that includes pre-payment clinical review of medical records and related infor-

mation to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements. The MAC may use any relevant information they deem necessary to conduct the review, including documentation submitted with the claim and additional information they request from the provider. However, only a small percentage of claims are subject to such pre-payment review. CMS pays MACs for pre-payment reviews based on the MACs’ costs to review the claims.

Claims are generally submitted to the MACs after the services are rendered, though certain services require prior authorization before the service is provided to the beneficiary. For those services, providers submit a request for prior authorization to the MAC, and the MAC reviews the request based on the associated Medicare requirements, such as those found in NCDs and LCDs, and provides a decision, which can be either provisional affirmation or non-affirmation.

WISeR Model Notice

On July 1, 2025, CMS issued the Notice announcing the implementation of the WISeR Model, a new process to evaluate claims for certain medical services under Original Medicare. The Notice explains that the WISeR Model will be tested for a six-year period beginning on January 1, 2026, in six states. According to CMS, the model “will focus on testing the implementation of prior authorization and pre-payment review for specific selected services that will be performed by third party entities leveraging enhanced technologies”—referred to as “model participants.” The model participants will implement an optional prior authorization process for the selected services to ensure they “are clinically appropriate, evidence-based, and consistent with Medicare . . . requirements.” CMS stated that it envisions that the model’s use of enhanced technology will streamline the process and identify when services are medically unnecessary, thereby supporting providers in navigating beneficiaries towards more clinically appropriate or higher value care.

The Notice states that for the selected services, providers will have the option to: (1) submit a request for prior authorization with supporting documentation to the relevant model participant; (2) submit a request for prior authorization with supporting documentation to the MAC (which will send the request to the model participant); or (3) perform the service without requesting prior authorization and then submit a claim, which

will be subject to pre-payment medical review by the model participant and may involve requests for supporting documentation.

Under options 1 or 2 described above, if the provider opts to seek prior authorization from either the model participant directly or via the MAC, the model participant will review the request and issue a provisional affirmation or non-affirmation. If the model participant provisionally affirms the request, the associated claim will generally be paid by the MAC. On the other hand, claims associated with a non-affirmed request will be denied by the MAC, and the denial would be subject to the existing administrative appeals process.

Under option 3, if the provider opts to furnish the service without requesting prior authorization and then submits a claim to the MAC, the MAC will flag the claim for pre-payment medical review, to be performed by the model participant. The model participant will request documentation from the provider to support the medical necessity of the claim, conduct a medical review, and then communicate its decision to the MAC, which will approve or deny the claim based on the model participant's decision. If the MAC denies the claim, the denial would be subject to the existing appeals process.

The Notice states that the WISer Model does "not change any medical necessity or documentation requirements" and "will require the same information and clinical documentation that is already required to support Medicare . . . payment but earlier in the process, namely, prior to the service being furnished." The Notice further states that the WISer Model "will not change payment or coverage for the selected services."

Regarding the model participants themselves, the Notice states that CMS will implement two three-year agreement periods with participants, which will be companies that have experience using technology-enhanced prior authorization with other payers, including Part C Medicare Advantage plans. The participants will be paid under a "novel payment approach," where they will be compensated based on a share of averted expenses from reducing unnecessary or non-covered services in lieu of the traditional acquisition-based approach.

The Notice states that the WISer Model is being implemented under section 1115A of the Social Security Act, 42 U.S.C. §1315a, which, according to the Notice, "authorizes the [HHS] Secretary to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries" and allows the Secretary to waive certain statutory requirements as may be necessary to test the models. The Notice states that pursuant to this authority, the agency is waiving specific statutory and regulatory provisions that could be construed as limiting its ability to conduct prior authorization or that could be construed to restrict what entity performs such prior authorization.

#### *Congressional Review Act (CRA)*

CRA, enacted in 1996 to strengthen congressional oversight of agency rulemaking, requires federal agencies to submit a report on each new rule to both houses of Congress and the Comptroller General for review before the rule can take effect. The report must contain a copy of the rule, "a concise general statement relating to the rule," and the rule's proposed effective date. CRA allows Congress to review and disapprove rules issued by federal agencies for a period of 60 days using special procedures. If a resolution of disapproval is enacted, then the new rule has no force or effect.

CRA adopts the definition of a rule under the Administrative Procedure Act (APA), which states that a rule is "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency." However, CRA excludes three categories of APA rules from coverage: (1) rules of particular applicability; (2) rules relating to agency management or personnel; and (3) rules of agency organization, procedure, or practice that do not substantially affect the rights or obligations of non-agency parties.

HHS did not submit a CRA report to Congress or the Comptroller General on the WISer Model Notice. In its response to us, HHS stated that, in its view, the WISer Model Notice is a guidance document and the CRA does not apply to guidance documents.

#### DISCUSSION

At issue here is whether the WISer Model Notice meets CRA's definition of a rule, which adopts APA's definition of a rule with three exceptions. As explained below, we conclude that the Notice meets the APA definition, and no exceptions apply. Therefore, the Notice is a rule subject to CRA's submission requirements.

#### *The WISer Model Notice is a Rule under APA*

Applying APA's definition of a rule, the WISer Model Notice meets all of the required elements. First, the Notice is an agency statement as it is an official document approved by the CMS Administrator and published by CMS in the *Federal Register*. Second, the WISer Model Notice is of future effect. An agency action of future effect is one "concerned with policy considerations for the future rather than the evaluation of past or present conduct." The Notice was published on July 1, 2025, and announced the future implementation of the WISer Model beginning on January 1, 2026.

Finally, the WISer Model Notice implements and prescribes law or policy and describes agency procedure and practice requirements. An agency statement implements, interprets, or prescribes law or policy when the action creates new regulations, changes regulatory requirements or official policy, or alters how the agency will exercise its discretion, among other things. The WISer Model Notice prescribes and implements new requirements for Original Medicare providers in selected states by mandating prior authorization or pre-payment medical review of claims for certain services. The Notice also prescribes and implements a new policy of having such claims reviewed by model participants—companies using enhanced technology, like AI or machine learning—and prescribes a new payment approach for those participants based on averted Medicare expenditures. In addition, the Notice implements section 1115A of the Social Security Act by establishing the WISer Model pursuant to that section and using its authority to waive certain statutory and regulatory provisions.

An agency statement describes agency organization, procedure, or practice requirements when the statement discusses the internal operations of an agency, including statements that govern the conduct of agency proceedings. The WISer Model Notice describes new procedures for the submission and processing of Original Medicare claims for certain services in selected states. In addition, the Notice outlines the method by which companies participating in the model will be compensated by CMS. Therefore, the Notice also describes agency organization, procedure, or practice requirements.

Having satisfied all the required elements, the WISer Model Notice meets the APA definition of a rule.

HHS stated in its response that it did not submit the WISer Model Notice because it is a guidance document and CRA does not apply to guidance documents. We have addressed in previous decisions HHS's position that guidance documents are not rules under CRA and rejected that interpretation. For example, we previously examined an HHS Information Memorandum informing states that HHS would use its statutory authority to waive certain requirements of the Temporary Assistance for Needy Families (TANF) program to allow states to test various strategies, policies, and procedures designed to improve employment outcomes for needy families. The Information Memorandum also set forth requirements that had to be met for a waiver request to be considered by HHS. HHS stated that the Information Memorandum was a non-binding guidance document and that guidance documents do not need to be submitted as rules under CRA. We rejected this position, noting that the APA definition of a rule "is expansive and specifically includes documents that implement or interpret law or policy." We also cited previous GAO decisions in which we concluded that "agency guidance, including guidance characterized as non-binding, constitutes a rule under the CRA." Finally, we pointed to relevant CRA legislative history listing guidance documents as an example of APA rules.

Like the Information Memorandum at issue in B-323772, Sept. 4, 2012, the WISer Model Notice implements a new policy and prescribes new procedures for non-agency parties.

As discussed above, the Notice satisfies all the elements of the APA rule definition and is a rule under APA, regardless of whether it is a guidance document.

#### *CRA Exceptions*

We must next determine whether any of CRA's three exceptions apply. CRA provides for three types of rules that are not subject to its requirements: (1) rules of particular applicability; (2) rules relating to agency management or personnel; and (3) rules of agency organization, procedure, or practice that do not substantially affect the rights or obligations of non-agency parties.

#### *(1) Rule of Particular Applicability*

The WISer Model Notice is not a rule of particular applicability. Such rules are addressed to specific, identified persons or entities and determine actions those persons or entities may or may not take, considering the facts and circumstances specific to those persons or entities. In determining whether a rule is one of general or particular applicability, we have noted that a rule need not apply to the population as a whole to be considered a rule of general applicability; rather, all that is required is that the rule has general applicability within its intended range, regardless of the magnitude of the range. In particular, we have determined that a rule is one of general applicability even if the rule is limited to a specific geographic area, so long as the rule does not apply to specific, identified persons or entities.

Although the WISer Model Notice announces the implementation of the model in six states, the Notice is not addressed to specific, identified persons or entities. Instead, the Notice applies to all providers of the specified services in those states, as well as the model participants. Therefore, the Notice is a rule of general applicability.

#### *(2) Rule of Agency Management or Personnel*

The WISer Model Notice is not a rule of agency management or personnel. This exception applies to rules relating to "purely internal agency matters." These include

rules related to controlling, directing, or supervising internal management issues, as well as rules related to personnel issues like pay, leave, or benefits. In contrast, we have determined that rules affecting agency proceedings with non-agency parties do not fall within this exception. For example, in B-337397, Aug. 27, 2025, we concluded that an HHS policy statement rescinding a prior policy generally requiring APA notice-and-comment procedures for certain rules did not fall within the exception because the policy statement changed public participation in certain HHS rulemakings and therefore did not relate primarily to agency management or personnel.

The WISer Model Notice involves neither internal management nor personnel issues. Instead, the Notice establishes new claims procedures for providers of the specified services in specific states. The Notice also establishes a new process by which such claims will be reviewed by model participants and prescribes a new payment approach for those participants. Therefore, the Notice does not meet this exception.

*(3) Rule of Agency Organization, Procedure, or Practice That Does Not Substantially Affect Non-Agency Parties*

The WISer Model Notice is not a rule of agency organization, procedure, or practice that does not substantially affect the rights or obligations of non-agency parties.

We have previously explained that this exception was modeled on the APA exception to notice-and-comment rulemaking requirements for “rules of agency organization, procedure, or practice,” which some courts have limited to rules that do not have a substantial impact on non-agency parties. The purpose of the APA exception is “to ensure that agencies retain latitude in organizing their internal operations.” Following this interpretation in the CRA context, we have only applied CRA’s third exception to rules that primarily focus on an agency’s internal operations.

Rules of agency organization, procedure, or practice include rules addressing the submission of information to an agency by non-agency parties, rules that affect how the agency reviews that information, and rules that affect the type or timing of actions the agency will take based on that submission. The WISer Model Notice qualifies as a rule of agency organization, procedure, or practice because it establishes new procedures for submitting and processing Medicare claims for certain services in specific states.

However, the Notice substantially affects the rights or obligations of non-agency parties. Rules that satisfy this exception do not alter the rights or interests of non-agency parties, though they may alter the manner in which parties present themselves or their viewpoints to the agency.

In particular, we have determined that rules that could affect the outcome of an agency proceeding substantially affect non-agency parties and do not fall within the exception. This includes changes to important procedural rights that could affect the outcome, even if they do not alter the substantive criteria used by the agency to make a decision. For example, we reviewed an HHS Policy Statement that rescinded a previous policy of generally requiring the use of APA notice-and-comment procedures for otherwise exempt rules relating to public property, loans, grants, benefits, or contracts. We noted that the Policy Statement eliminated the public’s right to notice and an opportunity to submit information that could affect HHS’s rulemaking decisions. Accordingly, we concluded that the Policy Statement substantially affected the rights of non-agency parties.

Further, in B-281575, Jan. 20, 1999, we reviewed Environmental Protection Agency (EPA) interim guidance for investigating discrimination complaints related to EPA permits. The guidance, in part, significantly departed from existing EPA procedures by requiring EPA to make an initial finding as to whether there were discriminatory effects associated with the relevant permit, and, if so, to notify the permit recipient and complainant and afford the recipient an opportunity to rebut EPA’s finding, propose a plan to mitigate the disparate impact, or seek to demonstrate that there was a legitimate interest that justified the decision to proceed notwithstanding the discriminatory effect. We concluded that by providing for an initial finding of discriminatory effects and allowing permit recipients to provide input at that stage—including justifications for the discriminatory effects—the guidance gave permit “recipients significant rights that they did not previously possess for obtaining dismissal of [a] complaint,” and thereby affected the rights and duties of recipients, complainants, and the affected population.

Similarly, courts have determined that a change in decision maker substantially affects the rights and interests of non-agency parties. For example, in *National Association of Home Health Agencies v. Schueiker*, the U.S. Court of Appeals for the D.C. Circuit examined the HHS Secretary’s administrative instruction regarding Medicare reimbursement for certain home health agencies. Prior to the instruction, those home health agencies had the option of submitting claims for Medicare reimbursement directly to the Secretary or to an intermediary contracted by HHS. The administrative instruction directed the relevant home health agencies to begin using intermediaries for all Medicare reimbursement determinations and payments, eliminating the option of seeking reimbursement from the Secretary. The court determined that the instruction substantially affected the rights and interests of the affected home health agencies because it eliminated their right to deal directly with the Secretary. In a more recent opinion, the D.C. Circuit emphasized that “[t]he crucial element of *Home Health Agencies* is . . . which staffers have decision[-]making authority.”

Similar to the administrative instruction at issue in *Home Health Agencies*, the WISer Model Notice effectively transfers decision-making authority for certain Medicare reimbursement claims, in this case from the MACs to the model participants. Although the MACs will continue to approve or deny claims, they are bound by the determinations of the model participants for claims related to the specified services. With respect to claims that are submitted for prior authorization, those that are provisionally affirmed by the model participant “will be paid in full, so long as all of the applicable Medicare coverage and clinical documentation are met, and the claim was billed and submitted correctly.” In contrast, if the model participant does not affirm the prior authorization request, “the MAC will deny the [subsequent] claim.” For claims not submitted for prior authorization, the model participant will perform a pre-payment medical review and communicate its decision to the MAC, and “[t]he MAC will then process the claim in accordance with the model participant’s decision.”

Not only does the WISer Model Notice effectively transfer decision-making authority over certain claims from the MACs to the model participants, that change could potentially affect whether claims are approved or denied given the participants’ novel approach to reviewing claims and their compensation structure. Specifically, the model participants will use advanced technologies,

like AI and machine learning, to determine whether the relevant services are medically necessary and providers should be reimbursed. In addition, the participants will be compensated based on their ability to reduce payments for unnecessary or non-covered services; in other words, model payments will be “calculated from requests that did not result in a paid claim.” This differs from the payment structure for MACs, which are paid based on the costs of reviewing claims.

Several medical organizations raised concerns to CMS that the WISer Model’s use of advanced technologies to review claims and the model participant compensation structure could result in inappropriate denials. For example, the American Medical Association (AMA) stated that “AI and other automated tools raise significant risks if not governed properly” and “[o]utdated, incomplete, or biased training data can lead to false positives, inappropriate denials, or unfair patterns of flagging services for certain patient populations.” With respect to the compensation structure, AMA stated that “[w]hen third-party entities are paid based on the volume of denied services, there is a clear risk that care that is medically necessary for certain patients will be inappropriately denied in pursuit of savings.” AMA therefore included a number of recommendations to mitigate these concerns.

Part of the purpose of the WISer Model is to test “the speed and accuracy of new technology-assisted decision-making,” and it is unclear what the ultimate effects of the model will be on coverage determinations in practice. In addition, we note that CMS has included measures to reduce inaccuracy, such as requiring that final non-affirmation decisions be made by licensed clinicians. However, because the purpose of our CRA determinations is to identify whether an action is a rule and should have been submitted to Congress before it took effect, we must assess the potential effects of the rule before they occur, not at some later time when those effects become known.

In this case, the WISer Model Notice transfers decision-making authority over certain Medicare claims to different entities that will use new technology-assisted processes to evaluate claims and will be compensated based on reducing Medicare expenditures. Given the nature of these changes and because they could potentially affect the determinations made on claims for the selected services, we conclude that the Notice substantially affects the rights and obligations of non-agency parties, specifically providers and beneficiaries of the selected services in the six states covered by the model.

HHS states in its response that its voluntary models do not alter or affect the rights of any party under any statute absent a voluntary decision to participate in the model and that the WISer Model does not change substantive Medicare eligibility, coding, coverage, or payment requirements.

However, despite HHS’s characterization and the fact that a third-party’s participation as a model participant may be voluntary, provider participation in the WISer Model is largely involuntary. Providers in the six states must use the model procedures for claims related to the selected services, including having those claims adjudicated by a model participant. The only choice such providers appear to have is the option to submit a prior authorization request for the service—not required previously—or to have their claim subject to pre-payment medical review by a model participant—a process previously applied to only a small number of claims. And as discussed above, the changes to the claims procedures—including the transfer of decision-making authority to the model participants, the processes they will

use to evaluate claims, and their compensation structure—could potentially affect the outcome of claims decisions, notwithstanding that the WISer Model Notice does not purport to change substantive Medicare eligibility, coding, coverage, or payment requirements. Accordingly, we conclude that the Notice substantially affects the rights and obligations of non-agency parties and does not fall within the third CRA exception.

CONCLUSION

The WISer Model Notice is a rule for purposes of CRA because it meets the definition of a rule under APA and no CRA exception applies. Therefore, the Notice is subject to CRA's requirement that it be submitted to Congress and the Comptroller General before it can take effect.

EDDA EMMANUELLI PEREZ,  
*General Counsel.*

100TH ANNIVERSARY OF SARGENT CORPORATION

Ms. COLLINS. Mr. President, I rise today to congratulate Sargent Corporation on 100 years of exceptional business growth and development. From a humble beginning in Alton, ME, the general contracting company has grown significantly, continuing to work with and for Mainers to better our State, one project at a time.

In 1926, Herbert E. Sargent set out to make a living, purchasing a used dumptruck for hauling in the summer and plowing in the winter. Through honest, hard work, Herb offered high-quality services for his community, and demand quickly grew. Just 4 years later, he ambitiously acquired a fleet of trucks and a bulldozer, taking on many more projects. Herb's son Jim took over the family's business in 1957, aiding his father and building on his reputation as an honest, reliable contractor. Two decades later, Jim became company president. In the 1990s, after some very successful projects near Baltimore, Sargent expanded beyond New England to the Mid-Atlantic region.

In 2013, the company's employees acquired 100 percent of the stock from Herb R. Sargent, the founder's grandson. Since then, the company has been entirely employee-owned. Today, more than 500 employee-owners throughout New England and the Mid-Atlantic remain invested in and supportive of the success of Sargent.

Sargent Corporation has bettered communities across the State through various projects, such as recent work at Eastport Airport, the Downeast Wind Farm, the Maine Turnpike, and many more. Through these public and private projects, Sargent's work has improved environmental health, energy production, and transportation infrastructure across the State. Due to the high quality of performance and record of safety at Sargent, the company has won a plethora of awards in my home State, including the Build Maine Award 16 times since 2010. These rewards affirm what I know firsthand about Sargent: The company has maintained their priorities in performance and safety.

Sargent Corporation was built on integrity, reliability, and hard work 100

years ago, and as they adapt with the times, these values hold true. Today, I thank Sargent for its tremendous impact on our communities and congratulate it on its milestone anniversary.

50TH ANNIVERSARY OF SAPPI NORTH AMERICA'S SOMERSET MILL

Ms. COLLINS. Mr. President, I rise today to congratulate Sappi North America, Inc., on 50 years of operations at the Somerset Mill in Skowhegan, ME. Since opening in 1976 on the banks of the Kennebec River, the Somerset Mill has grown into one of the most technologically advanced paper mills in North America. Today, the mill manufactures high-quality paper products from trees harvested in Maine and is known for its longstanding commitment to its employees and the surrounding community.

The Somerset Mill employs approximately 780 skilled workers, making it one of the largest employers in Maine. The facility operates three state-of-the-art paper machines, with a total annual production capacity of 1.25 million tons. The mill produces coated freesheet paper commonly used for magazines, brochures, and direct mail advertising. It is also a leading producer of paper and paperboard used in packaging, labels, graphic papers, and grease-proof paper for food packaging.

Project Elevate, a \$500 million modernization investment completed last year, doubled the production capacity of Paper Machine No. 2. These recent investments in the Somerset Mill reflect the steadfast devotion Sappi holds to producing quality products and responding to market demands, further strengthening Sappi's position as a leader in sustainably manufactured paperboard.

Sappi North America has undertaken significant efforts to reduce greenhouse gas emissions. The Somerset Mill generates much of its energy on-site using biomass from papermaking byproducts, namely bark and wood chips. Sappi also has an approved Science Based Targets Initiative goal to reduce its carbon emissions by 41 percent by 2030. Additionally, the Somerset Mill holds triple certification from the Forest Stewardship Council, Sustainable Forestry Initiative, and Programme for the Endorsement of Forest Certification. These accolades reflect Sappi's continued effort to maintain the long-term well-being of Maine's invaluable natural environment.

Sappi's Somerset Mill has been recognized for its attention to the safety of its employees. In 2023, for the first time in its 50-year history, the pulp mill completed the fiscal year without a recordable injury. The mill also achieved 1 million hours without a Lost Time Injury and received a Gold Award through Sappi's global Safety Recognition Awards program.

The mill's impact extends beyond its operations and into the surrounding

community. In 2026, Sappi's Somerset Mill leadership was named Large Business of the Year by both the Mid-Maine Chamber of Commerce and the Skowhegan Area Chamber of Commerce. In 2025, Sappi North America CEO Mike Haws was recognized as the MaineBiz Leader of the Year. In 2023, the Somerset Mill received the Somerset County Champions Award at the Heart of Maine United Way campaign kickoff event after raising 30 percent of the county's total United Way workplace campaign contributions.

I congratulate Sappi North America and all the employees of the Somerset Mill on this milestone anniversary and thank them for their continued contributions to Maine's economy, paper industry, and communities.

TRIBUTE TO DR. JOHN RAYMOND

Ms. BALDWIN. Mr. President, I rise today to pay tribute to Dr. John Raymond, one of Wisconsin's most distinguished physicians, educators, researchers, and institutional leaders. Serving as president of the Medical College of Wisconsin (MCW) since 2010, Dr. Raymond will be stepping down as President and transitioning to a faculty role in June of 2026.

The career of Dr. Raymond is marked by his exceptional commitment to public service and the well-being of not only Milwaukee, but the entire State of Wisconsin. For 16 years he has worked extensively with my office to ensure we create the best possible health legislation for our constituents, while deftly navigating numerous challenges, including the COVID-19 pandemic.

A native of Akron, OH, Dr. Raymond graduated from Ohio State University in 1978 and earned his medical degree there in 1982. He began his career as a faculty member at the world-renowned Duke University Medical Center. Dr. Raymond later became the associate chief of staff of the Ralph H. Johnson VA Medical Center in Charleston, SC, before moving into academic administration as vice president for academic affairs and provost of the Medical University of South Carolina. Eventually, Dr. Raymond came to Wisconsin, assuming his tenure as president of MCW in 2010.

Dr. Raymond arrived at MCW with a mandate and a vision he articulated clearly in his installation address: "Strength Through Collaboration." That phrase, far more than mere rhetoric, proved to be the guiding principle of 16 transformational years. Under his stewardship, MCW, Wisconsin's only private medical school, grew from a \$798.4 million institution into a \$1.61 billion enterprise, more than doubling its top-line revenue and reflecting the profound expansion of MCW's reach, capacity, and national stature.

Today, in partnership with Froedtert Health, Children's Wisconsin, and the Clement J. Zablocki VA Medical Center, MCW contributes \$5.82 billion annually in direct operational impact to