availability. This critical test can identify carrier couples before a tragedy occurs. Raising awareness of this terrible disease is important, but it is critical that we also put the words into actions.

Millions of Americans who suffer from rare diseases like Tay-Sachs and more common diseases like cancer stand to benefit from an expanded Federal commitment to stem cell research. We must also continue to increase funding for the National Institutes of Health. Federal support for cutting-edge biomedical research will make treatments and cures for diseases like Tay-Sachs a reality.

I urge my colleagues to support House Resolution 1333 and Tay-Sachs Awareness Month.

Mr. PALLONE. Madam Speaker, I have no further speakers, and I would urge support of the legislation.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and agree to the resolution, H. Res. 1333, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution, as amended, was agreed to.

A motion to reconsider was laid on the table.

HEALTH CARE SAFETY NET ACT OF 2008

Mr. PALLONE. Madam Speaker, I move to suspend the rules and concur in the Senate amendment to the bill (H.R. 1343) to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, and for other purposes.

The Clerk read the title of the bill.

The text of the Senate amendment is as follows:

Senate amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Safety Net Act of 2008''.

SEC. 2. COMMUNITY HEALTH CENTERS PROGRAM OF THE PUBLIC HEALTH SERVICE ACT.

(a) ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR THE HEALTH CENTERS PROGRAM OF PUBLIC HEALTH SERVICE ACT.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by amending paragraph (1) to read as follows:

''(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

''(A) $2,065,000,000 for fiscal year 2008;

''(B) $2,313,000,000 for fiscal year 2009;

''(C) $2,602,000,000 for fiscal year 2010;

''(D) $2,940,000,000 for fiscal year 2011; and

''(E) $3,337,000,000 for fiscal year 2012.''.

(b) STUDIES RELATING TO COMMUNITY HEALTH CENTERS.—

(1) DEFINITIONS.—For purposes of this subsection—

(A) the term ''community health center'' means a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b); and

(B) the term ''medically underserved population'' has the meaning given that term in such section 330.

(2) SCHOOL-BASED HEALTH CENTER STUDY.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall issue a study of the economic costs and benefits of school-based health centers and the impact on the health of students of these centers.

(B) CONTENT.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall analyze—

(i) the impact that Federal funding could have on the operation of school-based health centers;

(ii) any cost savings to other Federal programs derived from providing health services in school-based health centers;

(iii) the effect on the Federal Budget and the health of students of providing Federal funds to school-based health centers and clinics, including the result of providing disease prevention and nutrition information;

(iv) the impact of access to health care from school-based health centers in rural or underserved areas; and

(v) other sources of Federal funding for school-based health centers.

(3) HEALTH CARE QUALITY STUDY.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this Act as the ''Secretary''), acting through the Administrator of the Health Resources and Services Administration, and in collaboration with the Agency for Healthcare Research and Quality, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes agency efforts to expand and accelerate quality improvement activities in community health centers.

(B) CONTENT.—The report under subparagraph (A) shall focus on—

(i) Federal efforts, as of the date of enactment of this Act, regarding health care quality in community health centers, including quality data collection, analysis, and reporting requirements;

(ii) identification of effective models for quality improvement in community health centers, which may include models that—

(I) incorporate care coordination, disease management, and other services demonstrated to improve care;

(II) are designed to address multiple, co-occurring diseases and conditions;

(III) improve access to providers through non-traditional means, such as the use of remote monitoring equipment;

(IV) target various medically underserved populations, including uninsured patient populations;

(V) increase access to specialty care, including referrals and diagnostic testing; and

(VI) enhance the use of electronic health records to improve quality;

(iii) efforts to determine how effective quality improvement models may be adapted for implementation by community health centers that vary by size, budget, staffing, services offered, populations served, and other characteristics determined appropriate by the Secretary;

(iv) types of technical assistance and resources provided to community health centers that may facilitate the implementation of quality improvement interventions;

(v) proposed or adopted methodologies for community health center evaluations of quality improvement interventions, including any development of new measures that are tailored to safety-net, community-based providers;

(vi) successful strategies for sustaining quality improvement interventions in the long-term; and

(vii) partnerships with other Federal agencies and private organizations or networks as appropriate, to enhance health care quality in community health centers.

(C) DISSEMINATION.—The Administrator of the Health Resources and Services Administration shall establish a formal mechanism or mechanisms for the ongoing dissemination of agency initiatives, best practices, and other information that may assist health care quality improvement efforts in community health centers.

(4) GAO STUDY ON INTEGRATED HEALTH SYSTEMS MODEL FOR THE DELIVERY OF HEALTH CARE SERVICES TO MEDICALLY UNDERSERVED AND UNINSURED POPULATIONS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on integrated health system models of at least 15 sites for the delivery of health care services to medically underserved and uninsured populations. The study shall include an examination of—

(i) health care delivery models sponsored by public or private non-profit entities that—

(I) integrate primary, specialty, and acute care; and

(II) serve medically underserved and uninsured populations; and

(ii) such models in rural and urban areas.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subparagraph (A). The report shall include—

(i) an evaluation of the models, as described in subparagraph (A), in—

(I) expanding access to primary, preventive, and specialty services for medically underserved and uninsured populations; and

(II) improving care coordination and health outcomes;

(III) increasing efficiency in the delivery of quality health care; and

(IV) conducting some combination of the following services—

(aa) outreach activities;

(bb) case management and patient navigation services;

(cc) chronic care management;

(dd) transportation to health care facilities;

(ee) development of provider networks and other innovative models to engage local physicians and other providers to serve the medically underserved within a community;

(ff) recruitment, training, and compensation of necessary personnel;

(gg) acquisition of technology for the purpose of coordinating care;

(hh) improvements to provider communication, including implementation of shared information systems or shared clinical systems;

(ii) determination of eligibility for Federal, State, and local programs that provide, or financially support the provision of, medical, social, housing, educational, or other related services;

(jj) development of prevention and disease management tools and processes;

(kk) translation services;

(ll) development and implementation of evaluation measures and processes to assess patient outcomes;

(mm) integration of primary care and mental health services; and

(nn) carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives; and

(ii) an assessment of—

(I) challenges, including barriers to Federal programs, encountered by such entities in providing care to medically underserved and uninsured populations; and

(II) advantages and disadvantages of such models compared to other models of care delivery for medically underserved and uninsured populations, including—

(aa) quality measurement and quality outcomes;

(bb) administrative efficiencies; and

(cc) geographic distribution of federally-supported clinics compared to geographic distribution of integrated health systems.

(5) GAO STUDY ON VOLUNTEER ENHANCEMENT.—

(A) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit a report to Congress, concerning the implications of extending Federal Tort Claims Act (chapter 171 of title 28, United States Code) coverage to health care professionals who volunteer to furnish care to patients of health centers.

(B) CONTENT.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall analyze—

(i) the potential financial implications for the Federal Government of such an extension, including any increased funding needed for current health center Federal Tort Claims Act coverage;

(ii) an estimate of the increase in the number of health care professionals at health centers, and what types of such professionals would most likely volunteer given the extension of Federal Tort Claims Act coverage;

(iii) the increase in services provided by health centers as a result of such an increase in health care professionals, and in particular the effect of such action on the ability of health centers to secure specialty and diagnostic services needed by their uninsured and other patients;

(iv) the volume of patient workload at health centers and how volunteer health care professionals may help address the patient volume;

(v) the most appropriate manner of extending such coverage to volunteer health care professionals at health centers, including any potential difference from the mechanism currently used for health care professional volunteers at free clinics;

(vi) State laws that have been shown to encourage physicians and other health care providers to provide charity care as an agent of the State; and

(vii) other policies, including legislative or regulatory changes, that have the potential to increase the number of volunteer health care staff at health centers and the financial implications of such policies, including the cost savings associated with the ability to provide more services in health centers rather than more expensive sites of care.

(c) RECOGNITION OF HIGH POVERTY.—

(1) IN GENERAL.—Section 330(c) of the Public Health Service Act (42 U.S.C. 254b(c)) is amended by adding at the end the following new paragraph:

''(3) RECOGNITION OF HIGH POVERTY.—

''(A) IN GENERAL.—In making grants under this subsection, the Secretary may recognize the unique needs of high poverty areas.

''(B) HIGH POVERTY AREA DEFINED.—For purposes of subparagraph (A), the term 'high poverty area' means a catchment area which is established in a manner that is consistent with the factors in subsection (k)(3)(J), and the poverty rate of which is greater than the national average poverty rate as determined by the Bureau of the Census.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after January 1, 2009.

SEC. 3. NATIONAL HEALTH SERVICE CORPS.

(a) FUNDING.—

(1) REAUTHORIZATION OF NATIONAL HEALTH SERVICE CORPS PROGRAM.—Section 338(a) of the Public Health Service Act (42 U.S.C. 254k(a)) is amended by striking ''2002 through 2006'' and inserting ''2008 through 2012''.

(2) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Subsection (a) of section 338H of such Act (42 U.S.C. 254q) is amended by striking ''appropriated $146,250,000'' and all that follows through the period and inserting the following: ''appropriated—

''(1) for fiscal year 2008, $131,500,000;

''(2) for fiscal year 2009, $143,335,000;

''(3) for fiscal year 2010, $156,235,150;

''(4) for fiscal year 2011, $170,296,310; and

''(5) for fiscal year 2012, $185,622,980.''.

(b) ELIMINATION OF 6-YEAR DEMONSTRATION REQUIREMENT.—Section 332(a)(1) of the Public Health Service Act (42 U.S.C. 254e(a)(1)) is amended by striking ''Not earlier than 6 years'' and all that follows through ''purposes of this section.''.

(c) ASSIGNMENT TO SHORTAGE AREA.—Section 333(a)(1)(D)(ii) of the Public Health Service Act (42 U.S.C. 254f(a)(1)(D)(ii)) is amended—

(1) in subclause (IV), by striking ''and'';

(2) in subclause (V), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(VI) the entity demonstrates willingness to support or facilitate mentorship, professional development, and training opportunities for Corps members.''.

(d) PROFESSIONAL DEVELOPMENT AND TRAINING.—Subsection (d) of section 336 of the Public Health Service Act (42 U.S.C. 254h–1) is amended to read as follows:

''(d) PROFESSIONAL DEVELOPMENT AND TRAINING.—

''(1) IN GENERAL.—The Secretary shall assist Corps members in establishing and maintaining professional relationships and development opportunities, including by—

''(A) establishing appropriate professional relationships between the Corps member involved and the health professions community of the geographic area with respect to which the member is assigned;

''(B) establishing professional development, training, and mentorship linkages between the Corps member involved and the larger health professions community, including through distance learning, direct mentorship, and development and implementation of training modules designed to meet the educational needs of offsite Corps members;

''(C) establishing professional networks among Corps members; or

''(D) engaging in other professional development, mentorship, and training activities for Corps members, at the discretion of the Secretary.

''(2) ASSISTANCE IN ESTABLISHING PROFESSIONAL RELATIONSHIPS.—In providing such assistance under paragraph (1), the Secretary shall focus on establishing relationships with hospitals, with academic medical centers and health professions schools, with area health education centers under section 751, with health education and training centers under section 752, and with border health education and training centers under such section 752. Such assistance shall include assistance in obtaining faculty appointments at health professions schools.

''(3) SUPPLEMENT NOT SUPPLANT.—Such efforts under this subsection shall supplement, not supplant, non-government efforts by professional health provider societies to establish and maintain professional relationships and development opportunities.''.

(e) ELIGIBILITY OF THE DISTRICT OF COLUMBIA AND TERRITORIES FOR THE STATE LOAN REPAYMENT PROGRAM.—

(1) IN GENERAL.—Section 338I(h) of the Public Health Service Act (42 U.S.C. 254q–1(h)) is amended by striking ''several States'' and inserting ''50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, Palau, the Marshall Islands, and the Commonwealth of the Northern Mariana Islands''.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 338I(i)(1) of such Act (42 U.S.C. 254q–1(i)(1)) is amended by striking ''2002'' and all that follows through the period and inserting ''2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

SEC. 4. REAUTHORIZATION OF RURAL HEALTH CARE PROGRAMS.

Section 330A(j) of the Public Health Service Act (42 U.S.C. 254c(j)) is amended by striking ''$40,000,000'' and all that follows through the period and inserting ''$45,000,000 for each of fiscal years 2008 through 2012.''.

SEC. 5. REAUTHORIZATION OF PRIMARY DENTAL HEALTH WORKFORCE PROGRAMS.

Section 340G(f) of the Public Health Service Act (42 U.S.C. 256g(f)) is amended—

(1) by striking ''$50,000,000'' and inserting ''$25,000,000''; and

(2) by striking ''2002'' and inserting ''2008''.

SEC. 6. EMERGENCY RESPONSE COORDINATION OF PRIMARY CARE PROVIDERS.

(a) IN GENERAL.—Subtitle B of title XXVIII of the Public Health Service Act (42 U.S.C. 300hh–10 et seq.) is amended by adding at the end the following:

''SEC. 2815. EMERGENCY RESPONSE COORDINATION OF PRIMARY CARE PROVIDERS.

''The Secretary, acting through Administrator of the Health Resources and Services Administration, and in coordination with the Assistant Secretary for Preparedness and Response, shall

''(1) provide guidance and technical assistance to health centers funded under section 330 and to State and local health departments and emergency managers to integrate health centers into State and local emergency response plans and to better meet the primary care needs of populations served by health centers during public health emergencies; and

''(2) encourage employees at health centers funded under section 330 to participate in emergency medical response programs including the National Disaster Medical System authorized in section 2812, the Volunteer Medical Reserve Corps authorized in section 2813, and the Emergency System for Advance Registration of Health Professions Volunteers authorized in section 319I.''.

(b) SENSE OF THE CONGRESS.—It is the Sense of Congress that the Secretary of Health and Human Services, to the extent permitted by law, utilize the existing authority provided under the Federal Tort Claims Act for health centers funded under section 330 of the Public Health Service Act (42 U.S.C. 254b) in order to establish expedited procedures under which such health centers and their health care professionals that have been deemed eligible for Federal Tort Claims Act coverage are able to respond promptly in a coordinated manner and on a temporary basis to public health emergencies outside their traditional service area and sites, and across State lines, as necessary and appropriate.

SEC. 7. REVISION OF THE TIMEFRAME FOR THE RECOGNITION OF CERTAIN DESIGNATIONS IN CERTIFYING RURAL HEALTH CLINICS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The second sentence of section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended by striking ''3-year period'' and inserting ''4-year period'' in the matter in clause (i) preceding subclause (I).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Georgia (Mr. DEAL) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Madam Speaker, I yield 3 minutes to the gentleman from Texas (Mr. GENE GREEN).

Mr. GENE GREEN of Texas. Madam Speaker, I want to thank the chairman of our Health Subcommittee of the Energy and Commerce for his patience with me over the last year and a half, and I think I sometimes wear out my welcome on hearings and on moving this bill. I rise in strong support of H.R. 1343, the Health Centers Renewal Act of 2008.

I would first like to thank Senator KENNEDY and Senator HATCH for sponsoring and moving this reauthorization through the Senate, and also our fellow Energy and Commerce Committee member CHIP PICKERING for his work on this bill and his service to both his State of Mississippi and our country.

The Community Health Centers Program is one of the great health care successes of our country. Forty years after the program was first enacted at the urging of President Lyndon Johnson, health centers are located in 6,000 sites in all 50 States and serve as the medical home and family physician to 17 million people in medically underserved areas nationally.

Community health centers have helped fill the medical void for low-income and uninsured individuals and in 2006, community health centers provided care for over 700,000 Texans. But communities like my district in Houston are in dire need of more community health centers. Houston has approximately 1 million uninsured, but only 10 federally qualified health centers and is desperately in need of more community health centers.

We are not the only district in the country facing a medical crisis with the uninsured and underinsured.

The Health Centers Renewal Act of 2008 will reauthorize the Health Centers Program and provide over $2 billion a year for health community centers throughout the United States. This increased funding will allow more medically underserved communities to build new health centers, expand their health centers, and provide more services like dental and mental health care. In fact, this bill would allow health centers to expand their services to over 22 million patients in the next 5 years, which is almost 50 percent more than they serve today. That's exactly why every Member of this House should support this bill.

Community health centers have demonstrated time and again that if properly funded by Congress, they can meet the Nation's tremendous need for quality, affordable health care. Community health centers are a vital safety net for the uninsured and underinsured in the country. With nearly 40 million uninsured and a health care crisis in our country right now, it would almost be irresponsible for anyone to vote against this bill.

I thank you for this time.

Mr. DEAL of Georgia. Madam Speaker, I, too, rise in support of this legislation and would like to yield such time as he may consume to the gentleman from Pennsylvania (Mr. TIM MURPHY) who was one of the active members of the Subcommittee on Health and Commerce from which this bill originally came.

Mr. TIM MURPHY of Pennsylvania. I thank Ranking Member DEAL, also Chairman PALLONE and Ranking Member BARTON and Chairman DINGELL for their work on this bill, but particularly to Representative GENE GREEN, the cosponsor of this legislation, for his hard work and commitment and also really for the teamwork that he engineered with the committee to work on this.

There are about 1,100 community health centers that employ about 6,000 physicians. They provide critically affordable primary care to more than 16 million people nationwide. It is important to note when people toss about numbers of the number of uninsured in America, and many of those uninsured are extra covered by Medicaid, many by their private plans; but these 16 million people we agree really are uninsured folks in America, and the community health centers are a place where they can have a quality health care home.

When we note that what happens with community health centers, what they provide in terms of primary care, dental care, podiatry, mental health care, and so many other areas that provide care, particularly in prenatal, it is of great concern that there simply are not enough physicians and other health care providers to give that care.

The greatest vacancy rates are in rural and inner city health centers where their vacancy rates range between 19 and 29 percent of the current workforce. These are shortages of physicians, nurse practitioners, physicians assistants, midwives, dentists; and all of those are open because the community health centers simply do not have the money to pay for all of those employees.

What I'm disappointed about in this bill—and I know Congressman GREEN worked very hard, as did Congressman DEAL to keep this in here—is the idea that we cannot let physicians volunteer at these centers. I know we're all jointly disappointed because the community health centers, if they were able to have physicians volunteer at these centers, they could be covered by the Federal Torts Claim Act. Otherwise, they have to rely on paying their own malpractice insurance, which could run tens of thousands, if not well over $100,000, and community health centers cannot afford to cover that cost. The legislation I offered would have allowed Good Samaritan doctors to volunteer their time helping those in need.

We have to come back to this next year because in the meantime, many people without health insurance, or who are underinsured, rely upon community health centers for a whole host of their care. I look forward to working with my House and Senate colleagues in the future to ensure that legislation allowing doctors, nurses, psychologists, and other specialists to volunteer their time at community health centers. We must make that a law in order to provide care for so many people who need it at, I might add, a very, very low cost.

Again, I thank Chairman DINGELL, Ranking Member BARTON, Chairman PALLONE, Ranking Member DEAL, and Representative GREEN for their hard work on this bill. Their impassioned teamwork to help provide care to those most in need is to be applauded.

Mr. PALLONE. Madam Speaker, I will reserve my time.

Mr. DEAL of Georgia. Madam Speaker, I have a speaker who will appear shortly. He was here just a second ago.

In the meantime, I would use the time to simply thank Mr. GREEN as the lead sponsor of this legislation. He's done an excellent job. He did work across party lines, and I thought we had a good product that came out of our Health Subcommittee and our entire committee and came from the floor of this House. I think it's important that we do that on bills of this nature.

I would like to also thank, in addition to Mr. MURPHY who's spoken on the Volunteer Doctors provision, Ms. DEGETTE who was interested in that as well. Unfortunately, that provision, along with a provision that Congressman BURGESS and Congressman STUPAK had for some alternative ways of providing additional care under the community health center model, which we had included in our bill on the House side, was not agreed to by our colleagues across the way.

However, the legislation before us today does require three GAO studies to look at all of the issues which we had originally addressed in the legislation that came from the House. Hopefully those GAO studies will confirm the wisdom of the House of including those provisions in the initial bill, and I look forward to seeing the results of those studies and perhaps our ability to revisit this issue of community health centers because I, too, believe that one of the ways we can accomplish greater access is to provide volunteer doctors with Federal tort claims protections so that they can use their services and their talents in community health centers which have a very difficult time attracting doctors in many of the rural areas, in particular.

I rise today in support of H.R. 1343, the "Health Centers Renewal Act," a critical piece

of legislation which will reauthorize Community Health Centers and the National Health Service Corps. Community Health Centers provide a fundamental element of our healthcare delivery system in our nation, providing much needed care for uninsured or under-insured individuals seeking very low cost healthcare services. These centers have, and continue to, impact communities across our country and provide a critical safety net for care for thousands of Americans every year. With nearly 47 million Americans living without health insurance, traditional pay-for services have become prohibitively expensive for many. With no remaining option for even the most basic healthcare services, our emergency rooms are being overwhelmed. Community Health Centers step in to fill that gap, relieving the strain on hospital emergency rooms which cost exorbitantly more to operate and are pressed beyond capacity.

H.R. 1343 reauthorizes Community Health Centers for five years while seeking to improve the access to, and quality of, services available under this program throughout the nation. This legislation requires the Government Accountability Office to conduct three studies, all of which will evaluate mechanisms through which the health center program can do more for our communities. First, GAO will evaluate the incorporation of integrated health systems as a model for improving the access to care for medically underserved populations. Second, GAO will also study the effects of implementing policies which would establish school-based health centers. Finally, this legislation will evaluate the potential benefits which could be achieved by extending federal liability protections to healthcare practitioners to encourage participation in Community Health Centers, both in their community as well as additional areas ravaged by hurricanes, earthquakes, floods, or other disaster situations. In light of the devastation in the Gulf Coast region just a few years ago, our healthcare delivery system was put to the ultimate test. Thousands upon thousands of victims were affected. While physicians and other healthcare professionals were ready and willing to answer the call to serve, concerns regarding medical liability turned them away from their call to service. This is an apparent problem an Congress must address this issue to avoid a repeat of this unfortunate situation in the future.

I believe this legislation represents a reasonable compromise, reflecting the priorities of the House, Senate, and healthcare industry, and provides much-needed reauthorization to this critical component of our nation's healthcare infrastructure. I would also like to express my appreciation to the National Association of Community Health Centers for working so well with House and Senate staff in order to craft this legislation before us today. Again, I am pleased to see this legislation on the floor today, and I encourage all of my colleagues to support this critical reauthorization of Community Health Centers.

At this time, I would like to yield to the gentleman from Mississippi, who is a member of this committee, who also has worked on this legislation, for such time as he may consume, Mr. PICKERING.

Mr. PICKERING. Thank you, Mr. DEAL, the gentleman from Georgia. I want to thank him for his leadership of the subcommittee as the ranking member and previously as the chairman of the subcommittee. I want to thank Congressman GENE GREEN for his work as we did work together in a bipartisan fashion, all the committee staff.

As I come close to the end of my service in Congress, I can think of no better thing to go out on as the reauthorization, the expansion, and the funding, and modernization of the community health centers for what they do to create healthy communities and strong communities and to help the families most in need in our States and districts back home and in small towns and cities.

I know from Mississippi, community health centers have made a tremendous difference after Katrina and getting those who were evacuated after a disaster the help, but more importantly, every day those mothers and the elderly and the low income who otherwise would not have the best care and affordable, accessible means. Community health centers have played a vital role to my home State of Mississippi, and I'm very proud to be a part of this reauthorization and to see it done before we leave this session.

I want to thank Mary Martha Henson for her tremendous work on this, as well as the other staff.

Mr. DEAL of Georgia. I have no further speakers on the floor, and I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 30 seconds to the gentleman from Texas.

Mr. GENE GREEN of Texas. Madam Speaker, I'm glad that we have a member of our Energy and Commerce Committee in the chair, and this is a great example of working together. I know my colleagues, both from Mississippi but also from Pennsylvania, we worked on other issues in this bill, and I would be more than happy to see what we can do next Congress.

But this way, we have a reauthorization of the community health centers, and we can always improve on them and look forward to working with them again, bipartisan, across the aisle, because all of us look forward to expanding health centers for our community.

Mr. PALLONE. Madam Speaker, I have no further requests for time. I would urge my colleagues on both sides of the aisle to support this critically important measure that will help ensure that all Americans have access to quality health care.

Mr. SHAYS. Madam Speaker, I strongly support the Health Centers Renewal Act, which will reauthorize the community health center program for five years and increase the program's funding. This continues the strong commitment we have shown to these centers over the past five years.

During the last reauthorization, this Administration has sought to double the amount of people receiving care through community health centers, from 10 million to 20 million.

Already, over 17 million individuals are receiving quality care, and half of these individuals are uninsured. So of our 46 million uninsured, nearly 8 million are receiving care from these centers.

By preventing costly hospitalizations and reducing the use of emergency care for routine services, it is estimated community clinics save the health care system over $6 billion annually.

I strongly support passage of this legislation so community health centers can continue providing high-quality, cost-effective care. I urge my colleagues to vote for this bill.

Mr. PALLONE. I yield back my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and concur in the Senate amendment to the bill, H.R. 1343.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the Senate amendment was concurred in.

A motion to reconsider was laid on the table.

MAKING A TECHNICAL CORRECTION IN THE NET 911 IMPROVEMENT ACT OF 2008

Mr. PALLONE. Madam Speaker, I ask unanimous consent that the Committee on Energy and Commerce be discharged from further consideration of the bill (H.R. 6946) to make a technical correction in the NET 911 Improvement Act of 2008, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

The text of the bill is as follows:

H.R. 6946

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

SECTION 1. TECHNICAL CORRECTION.

(a) AMENDMENT.—Section 6(c)(1)(C) of the Wireless Communications and Public Safety Act of 1999 (47 U.S.C. 615a–1(c)(1)(C)) is amended by striking ''paragraph (2)'' and inserting ''paragraph (3)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as of July 23, 2008, immediately after the enactment of the NET 911 Improvement Act of 2008 (Public Law 110–283).

The bill was ordered to be engrossed and read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

□ 1715

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H.R. 1014, de novo;

H.R. 6950, de novo;

H. Res. 1421, by the yeas and nays.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.