



United States  
of America

# Congressional Record

PROCEEDINGS AND DEBATES OF THE 111<sup>th</sup> CONGRESS, FIRST SESSION

Vol. 155

WASHINGTON, TUESDAY, DECEMBER 8, 2009

No. 183

## Senate

The Senate met at 10 a.m. and was called to order by the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois.

### PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

God of wonder, beyond all majesty, may our lives and our world be awakened by Your grace. Open our eyes to Your works and our ears to Your words of life.

Stir within our lawmakers a desire to please You. Enable them to hear with objectivity and respond with integrity, as they comprehend their individual and collective responsibilities. Lord,

make them exemplary models of the highest and finest in faithful, loyal, and dedicated leadership. Give them wisdom, strength, and clarity to meet today's daunting challenges.

We pray in Your great Name. Amen.

### PLEDGE OF ALLEGIANCE

The Honorable ROLAND W. BURRIS led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

### APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,  
PRESIDENT PRO TEMPORE,  
Washington, DC, December 8, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois, to perform the duties of the Chair.

ROBERT C. BYRD,  
President pro tempore.

### NOTICE

If the 111th Congress, 1st Session, adjourns sine die on or before December 23, 2009, a final issue of the *Congressional Record* for the 111th Congress, 1st Session, will be published on Thursday, December 31, 2009, to permit Members to insert statements.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT-59 or S-123 of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Wednesday, December 30. The final issue will be dated Thursday, December 31, 2009, and will be delivered on Monday, January 4, 2010.

None of the material printed in the final issue of the *Congressional Record* may contain subject matter, or relate to any event, that occurred after the sine die date.

Senators' statements should also be formatted according to the instructions at [http://webster/secretary/cong\\_record.pdf](http://webster/secretary/cong_record.pdf), and submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at "Record@Sec.Senate.gov".

Members of the House of Representatives' statements may also be submitted electronically by e-mail, to accompany the signed statement, and formatted according to the instructions for the Extensions of Remarks template at <http://clerk.house.gov/forms>. The Official Reporters will transmit to GPO the template formatted electronic file only after receipt of, and authentication with, the hard copy, and signed manuscript. Deliver statements to the Official Reporters in Room HT-59.

Members of Congress desiring to purchase reprints of material submitted for inclusion in the *Congressional Record* may do so by contacting the Office of Congressional Publishing Services, at the Government Printing Office, on 512-0224, between the hours of 8:00 a.m. and 4:00 p.m. daily.

By order of the Joint Committee on Printing.

CHARLES E. SCHUMER, *Chairman*.

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.



Printed on recycled paper.

S12647

Mr. BURRIS thereupon assumed the chair as Acting President pro tempore.

#### RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

#### SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health reform legislation. Following leader remarks, the time until 12:30 will be for debate only. The majority will control the first half of the time allotted until 12:30. The Republicans will control the next half. The remaining time will be equally divided and controlled between the two leaders or their designees. The Senate will recess from 12:30 until 2:15 p.m. to allow for the weekly caucus luncheons. There are two amendments now pending. One is the Nelson of Nebraska amendment and the other is the McCain motion to commit. Senators should expect votes after the recess in relation to the pending amendment and motion.

#### NEW DEMOCRATIC SENATORS

Mr. REID. Mr. President, we have scheduled this morning, as soon as the leader time is used, a group of Democratic Senators. These are all new Senators. I hope those people who are watching understand the quality of the people who are now going to make a presentation before this body. The States that will be represented here today will be Oregon, Delaware, New Hampshire, Colorado—we have two Colorado Senators who will speak—the new Senator from Massachusetts, New Mexico, Virginia, Illinois, Alaska, and the opening will be by Senator MERKLEY and the closing will be by Senator MERKLEY. Such quality individuals we are so fortunate to have in the Senate. I am grateful for the time they have taken to speak on this issue. Much of what they have done has set the tone for this debate on our side of the aisle. It has been constructive, it has been positive, and it has been very lucid. They were all successful individuals before they came to the Senate. Certainly, that is acknowledged every time we hear one of them say a word here on the Senate floor.

Would the Chair announce the matter before the Senate.

#### RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

#### SERVICEMEMBERS HOME OWNERSHIP TAX ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the

Senate will resume consideration of H.R. 3590, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Nelson (NE) amendment No. 2962 (to amendment No. 2786), to prohibit the use of Federal funds for abortions.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 12:30 p.m. will be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each, with the majority controlling the first hour and the Republicans controlling the next hour.

#### RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

#### HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, over the past several days, Americans have seen in vivid detail what some supporters of this plan plan to do for the Medicare Program for seniors. They plan to use it as a giant piggy bank to pay for an entirely new government program. Yesterday, we heard floated, for the very first time, that they want to radically expand Medicare. So what is becoming abundantly clear is that the majority will make any deal, agree to any terms, sign any dotted line that brings them closer to final passage of this terrible bill. They entertain adding new experiments without any assessment of the impact this backroom deal-making will have on the American people or our economy. They are, for lack of a better term, winging it on one of the most consequential pieces of legislation affecting our country in memory.

Let me suggest to the majority, Americans would much rather we get it right than scurry around, throwing together untested, last-minute experiments in order to get 60 votes before Christmas. Let me say that again. Americans would much rather we get it right than scurry around, throwing together untested, last-minute experiments in order to get 60 votes before Christmas.

Over the past several days, our friends on the other side repeatedly voted to preserve nearly \$½ trillion in Medicare cuts to finance their vision of reform, a vision that includes cutting nearly \$8 billion from hospice care, \$40 billion in cuts to home health agencies, \$120 billion in cuts to Medicare Advantage, \$135 billion in cuts to hospitals that serve Medicare patients, and nearly \$15 billion in cuts to nursing homes. What these cuts really illustrate is a lack of vision because cutting one trou-

bled government program in order to create another is a mistake. I will say that again: \$½ trillion in cuts to Medicare for seniors is not reform.

But Medicare cuts are just one leg of the stool holding up this misguided vision of reform. Let's take a look at another. Let's look at how this bill punishes not only seniors but how it kills jobs at a time when 1 in 10 working Americans is looking for one. This bill doesn't just punish seniors, it punishes job creators too.

That is the message we got yesterday from small businesses across the country. They sent us a letter opposing this bill because it doesn't do the things proponents of this bill promised it would. It doesn't lower costs, it doesn't help create jobs, and it doesn't help the economy. Here are just some of the groups that signed that letter: the Associated Builders and Contractors, the Associated General Contractors, the International Food Service Distributors Association, the National Association of Manufacturers, the National Association of Wholesale Distributors, the National Retail Federation, Small Business and Entrepreneurship Council, and the U.S. Chamber of Commerce.

Here is what these groups had to say about this bill. I am reading from their letter dated December 7, 2009, a letter that was addressed to every Member of the Senate:

In order to finance part of its \$2.5 trillion price tag, HR 3590 imposes new taxes, fees and penalties totaling nearly half a trillion dollars. This financial burden falls disproportionately on the backs of small business. Small firms are in desperate need of this precious capital for job creation, investment, business expansion, and survival.

The letter goes on to detail all the ways in which this bill punishes small businesses, thus making it harder for them to retain or hire workers. These groups point out that under this bill, small businesses in the United States would see major cost increases as a result of new taxes on health benefits and health insurance, costs that would be passed on to employees and which would make health insurance more expensive, not less.

Under this bill, self-employed business owners who buy coverage for themselves could see a double-digit jump in their insurance premiums. For other small businesses, the bill won't lead to a significant decrease in cost—something they were promised as a result of the bill.

Under this bill, jobs would be lost and wages depressed as a result of a new law that would require businesses either to buy insurance for their employees or to pay a fine.

Needless to say, this is not the kind of legislation the American worker needs or wants at a moment of double-digit unemployment. Perhaps that is the reason that poll after poll after public opinion poll shows that the American worker opposes this bill.

Some business groups may have supported this plan earlier in the year because they thought it was inevitable.

They didn't want to be critical of a bill they thought they had no power to stop. But something happened between then and now: The American people realized what this bill meant for them. They realized what it would mean for seniors, for business owners, for the economy, for our future as a country. Americans stood up, they made their voices heard, and now the tide has turned. The American people oppose this bill. They want us to start over. They want us to make commonsense, step-by-step reforms that everyone can support, not some backroom deal to have the government take over the health care system that is then forced on the American people without discussion.

Our friends on the other side can read the writing on the wall. They know the American people oppose this bill. But they have apparently made a calculation to force it through Congress over the next several days before the American people even have a chance to absorb the details. The only thing that can stop them is the realization by Democrats themselves that this plan would be a tragic mistake for seniors, for the economy, and for our country and that a better path would be the kind of step-by-step reforms Americans have been asking of us, reforms Americans really want. Americans don't think reform should come at the expense of seniors, and they don't think it should come at the expense of jobs. They don't think it should make current problems worse.

TARP

Mr. President, we are now hearing talk that the administration is thinking of using the bank bailout TARP money that taxpayers reluctantly handed over during last year's credit crisis on another spending spree like the stimulus which they said would stop unemployment at 8 percent but hasn't. One trillion dollars later, unemployment is now at 10 percent. This is not only irresponsible, since the purpose of these emergency funds was to prop up the credit system in the midst of a crisis, it also violates both current law and the pledge we made that every dollar we got back would be returned to the taxpayer to reduce the national debt. That is the pledge we made when we passed the TARP proposal.

This proposal from the administration is completely wrongheaded, but it is perfectly illustrative of the way Democrats in Congress have been dealing with taxpayer money all year—by throwing it at one problem after another without much regard for the consequences. Whether it is the stimulus, Cash for Clunkers, or the health care bill that is currently on the Senate floor, Americans are running out of patience with politicians who promise jobs but who deliver nothing but more debt, higher taxes, and longer unemployment lines.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, I would like to take a moment to lay out today's program. It has been more than 2½ weeks since the majority leader moved to proceed to the health care reform bill, and this is the ninth day of debate. The Senate has considered 18 amendments or motions. We have conducted 14 roll-call votes.

Today, the Senate will debate the amendment by the Senator from Nebraska, Mr. NELSON, on a woman's right to choose. At the same time, we will debate the motion by Senator MCCAIN on Medicare Advantage.

The time between now and the caucus lunches is for debate only. The majority will control the first hour of debate this morning; the Republicans will control the second hour.

We are hopeful the Senate will be able to conduct votes on or in relation to the Nelson amendment, a side-by-side amendment to the McCain motion, and the McCain motion sometime this afternoon.

Thereafter, we expect to turn to another Democratic first-degree amendment, which is likely to be the amendment by the Senator from North Dakota, Mr. DORGAN, on drug reimportation, and another Republican first-degree amendment. We are working on lining up those amendments.

I note that the pending McCain motion is the third such effort by the Republicans to defend the private insurance companies that run the program called Medicare Advantage. That is the same so-called Medicare Advantage Program that the nonpartisan MedPAC says is overpaid—overpaid by 14 percent—compared with traditional Medicare, which does the same thing.

That is the same so-called Medicare Advantage Program whose overpayments add \$90 to the Medicare premiums of a typical retired couple, even though that couple gets nothing in exchange.

That is the same so-called Medicare Advantage Program that has been the major source of strong profits for the private insurance companies that receive those overpayments. And that is the same so-called Medicare Advantage Program that helps those private insurance companies to pay their CEOs \$8 million a year, \$9 million a year, and in one instance more than \$20 million a year in compensation.

So that is the same so-called Medicare Advantage Program that, in our view, needs a healthy dose of competition. That is all our bill would do. Our bill would move to competitive bidding in the private insurance Medicare market. It is high time we did so.

This morning we are going to have a colloquy among many new Senators, the group of Senators who were just elected last year, which is a very active group. I have met with them many times. They are very thoughtful, very active, and they have a lot to say.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I will be very brief because we want to take the time to hear from our colleagues. I, too, want to commend them. A number of them serve on the Health, Education, Labor, and Pensions Committee and were tremendously valuable in helping us craft the legislation we now have before us in this compromised, melded bill.

I also want to make a note. I listened to the Republican leader this morning—and I will talk more about this later—but you would almost begin to believe that 300 days ago Barack Obama arrived as President of the United States, and all these problems emerged miraculously. The fact is, in the previous 8 years we watched the Nation accumulate more debt in one administration than all prior 43 administrations combined.

The situation we find ourselves in economically did not happen overnight. It happened over a number of years of carelessness, with a lack of regulation and a lack of the enforcement of the regulation that existed. We have been grappling with these problems. In December of last year, more than 700,000 people lost their jobs—in that 1 month alone. In January, almost 700,000 again, and the same was true in March. Almost 3 million jobs were lost before the ink on the inauguration papers was dry.

We are now finding ourselves—while still too high an unemployment rate—with a vastly improved economic condition in this country. Much more needs to be done. Yet we hear the same sort of “Chicken Little” arguments. Just say no, every time, to an idea that might make a difference to this country getting back on its feet again.

Certainly the decisions made a year ago to provide the stabilization of major financial institutions contributed directly to the benefits we are seeing today. Certainly the efforts of taking some of these resources that have gone to bail out major financial institutions now being used to try to create jobs in the country is something I think would be welcomed by the American people—not rejected by Members of Congress who seem only to be interested in whether we are going to take care of those large firms that got us into this mess in the first place.

So I welcome the President's ideas in this area. We welcome particularly this effort on health care, to make a difference not only for individuals but for our economy, to reduce those costs, reduce those premiums, and make those insurance products available to all Americans who worry every night about whether they are going to fall into that abyss because of a health care crisis that happens to a family member or a loved one.

So today we are going to hear from a number of our colleagues who have been deeply engaged in these issues over the last several years and in their new membership in this wonderful body of the Senate. I welcome tremendously their efforts.

Mr. President, I yield the floor to allow them to discuss their ideas. I believe the first one to speak is our new colleague from Delaware.

The ACTING PRESIDENT pro tempore. The Senator from Delaware is recognized.

Mr. KAUFMAN. Mr. President, I want to start by agreeing—and I practically always agree with the Senator from Connecticut—with his summation as to how we got to where we are, and why it is important we do something about it. He is right. The chairman of the Finance Committee is right too.

The freshman Senators who come from all over this country got together and, frankly, with the leadership of Senator WARNER from Virginia, put together a package which I think is a very constructive package for the Health Care Reform Act we have to pass.

I appreciate the opportunity to join with the other freshmen, including the Acting President pro tempore, to discuss the unique opportunity we have to finally enact meaningful health care reform.

Make no mistake, we need health care reform now. When you look out there and you see everything from rising premiums to insurers denying coverage for people with preexisting conditions, the health care system is failing individual Americans. There is no doubt about that.

Not only is it doing that, it is threatening the fiscal solvency of our country. Medicare and Medicaid are swallowing up more and more of our Federal spending. If we do not act soon, it will become the largest contributor to the deficit.

The time for reform is now. We cannot wait any longer. As the Senator from Connecticut said, this is not something that just came out of nowhere. It has been there for a long time. But we cannot let any more time go by. We have to act now.

Thanks to the hard work of Senators REID, BAUCUS, DODD, and HARKIN and their staffs, we have a bill before us that can finally reform our health care system. It is a good bill. It is a bill that truly protects what works in our system and, at the same time, fixes what is broken.

No longer will Americans be denied coverage on the basis of preexisting conditions. No longer will their coverage be revoked when they get sick and need it the most. This bill will help protect seniors by offering new preventive and wellness benefits.

It will extend the solvency of the Medicare trust fund by an additional 5 years. It will also help our economy by significantly cutting health care costs and reducing the Nation's deficit by \$130 billion.

You hear a lot of numbers. You see a lot of numbers. You read about it in the newspaper. Especially, you hear about it on the other side of the aisle. This will cut the deficit by \$130 billion for the first 10 years and maybe up to

\$650 billion in the second 10 years. This will truly bend the cost curve, which we have to do if we are not going to go into insolvency.

It is interesting, when the other side talks about deficits, deficits, deficits—the thing that is driving the deficit is health care costs because what drives Medicare and Medicaid costs is health care costs.

This bill makes quality, affordable health care within reach of all Americans. But there is always more we can do. That is why I am pleased to join my other freshman colleagues to support a very promising amendment to the bill.

So much of what is broken in our present health care system revolves around basic inefficiencies that drive up costs, while simultaneously driving down quality. That is right. Costs go up, quality goes down. That is not the way we want to have it. We want costs to go down and quality to go up.

Even worse, inefficiencies in the system often give way to the waste, fraud, and abuse that drains somewhere between \$72 and \$220 billion annually from doctors, patients, private insurers, and the State and Federal Governments. This is significantly increasing health care costs for Americans. These are inefficiencies that can and will be curbed.

By seeking creative ways to encourage innovation and lower costs even further—and more quickly—for Americans across the country, this amendment complements the underlying health care bill.

It adopts the full spectrum of 21st-century technologies and innovative methods of delivery to further cut through the redtape that continues to plague our system and stifle innovation. It provides commonsense, practical solutions that help contain costs, improve value, and increase quality. It increases penalties for health care fraud and enhances enforcement against medical crooks and utilizes the most sophisticated technology to better detect and deter fraud in the health care system.

It quickens the implementation of uniform administrative standards, allowing for more efficient exchange of information among patients, doctors, and insurers. It provides more flexibility in establishing accountable care organizations that realign financial incentives and help ensure Americans receive high-quality care. It provides greater incentives to insurers in the exchange to reduce health care disparities along racial lines.

These are just a few examples of the provisions in the amendment that I believe will mesh well with the Patient Protection and Affordable Care Act. As I have said before, it is time to gather our collective will and do the right thing during this historic opportunity by passing health care reform now. I think this amendment can help us reach that goal. We cannot afford to wait any longer. We need to act now. We can do no less. The American people deserve no less.

Thank you, Mr. President.

The ACTING PRESIDENT pro tempore. The Senator from Virginia is recognized.

Mr. WARNER. Thank you, Mr. President.

I thank my colleague, the Senator from Delaware, for his comments and for his leadership on this issue. I also thank all of the freshmen. This is, I think, the seventh time the freshmen have come to the floor on this very important issue. Our colleagues have had to now endure 65 speeches from the freshmen on the subject of health care.

Before I get into my remarks, I want to personally thank Senator BAUCUS, Senator DODD, the majority leader, and their staffs, for working with the 11 freshmen Members who have come together today to unveil a package of health care amendments focused on the issue of cost containment.

We have been working on this now for close to 3 months.

Let me say at the outset, I am proud of the enormous broad-based support we are receiving for this package of amendments. The Business Roundtable has endorsed the amendments. Companies such as Walmart, Intel, Target and Quad/Graphics endorse this package. Groups such as the AARP and the AFL, and important think tanks such as the New America Foundation have endorsed this package. We also have support from Mark McClellan, who was the head of CMS under President Bush. While the merged bill starts to move us in the right direction in addressing health care spending in this country, this package strengthens that movement. Our package further moves us away from a current system that makes no financial sense—one that rewards volume over quality and one that reimburses hospitals for higher, rather than lower, readmission rates.

We are taking the payment reform aspects of the health care bill—sections that increase accountability, and focus on data mining and administrative simplification—and accelerating them. We are giving the Secretary, as we move forward, the ability to take pilot programs and broaden their approach and appeal. And if it works, we'll bring that reform to our whole system.

While we anticipate a very good score from CBO in terms of lowering health care costs overall, another thing we focused on with this package is not just health care reform in the context of government-related programs, such as Medicare and Medicaid, but also how we partner with those in the private sector.

One of the reasons the Business Roundtable is so supportive is the fact that our package recognizes that well over half of the American public still receives their health care through private insurance or in conjunction with their employers. With these amendments, we look at how we take the best of the private sector, and the lessons we've learned from them, and bring those into health care reform.

My friend, the Senator from Delaware, has raised this point. There are still issues to be resolved in this bill.

I still have some concerns, particularly with the public option portion. But I know that with a good-faith effort, we are going to get those issues resolved.

One thing that needs to be reaffirmed, time and time again, is what happens if we don't enact health care reform. Not acting is a policy choice; it is every bit as much of a policy choice as moving forward on this bill. What many don't realize is that the largest driver of our Federal deficit is not education funding, transportation funding, and not even TARP funds or the stimulus. The largest driver of our Federal deficit is health care spending.

If we fail to act now, Medicare, which provides health care to millions of senior citizens, will go bankrupt in the next 8 years. If we fail to act now, an average Virginia family will see their health care costs eat up 40 percent of their disposable income in the next decade.

One of the reasons we are seeing so much broad-based business support for our amendment package is business understands that if we can't drive down overall health care costs, the ability of the United States to come out of this recession and remain competitive in a global marketplace will be seriously undermined. As long as American business has to pay twice as much per person—as much as \$3,000 to \$4,000 more per employee—for their health care costs than any of our industrial competitors around the world, regardless of how productive the American workforce is, American businesses will be at a serious disadvantage.

Our amendment package is complex. It is a bit dense. There are some 30-odd different provisions that take very good parts of the merged bill and move them faster. It increases price transparency in health care pricing, and increases our ability to take programs and pilots that work and roll them out on a wider basis. My good friend, the Senator from Colorado, has been working hard on the administrative reform portion.

This is a good package of amendments. I was asked yesterday by somebody in the press how I would describe the package. I guess I would sum it up—because some of this stuff gets fairly dense—with two things that this package of amendments is trying to do.

I think we all remember, years back, in the travel industry, when you called up and tried to get an airline reservation and depending on whom you called and what time you called, you might get a totally different price on your airline ticket. Well, this package of amendments is trying to do for health care what Travelocity did for the airline business. And that is bring some true pricing transparency to the health care system.

Our package of amendments will move us—it will not get us all the way

there—but it will move us further down the field. I say this modestly, again, to the originators of the bill—it is a very good bill, a very good framework. But humbly I might say, as some know, I was lucky enough in the old days to fall into the cell phone industry. I managed to eke out a small living in that industry. I like to think about the cell phone industry as a metaphor for this package of amendments. If we think of the original bill as creating the cell phone of the 20th century, our package of amendments is basically the iPhone version to your Motorola flip phone original version. We literally provide dozens of new applications on a good, basic framework that has been provided by this merged bill. And we take these applications a little bit further into the 21st century.

I am very proud of the work all these freshmen Senators and their staffs have done over the last 3 or 4 months. Again, I thank the chairman of the Finance Committee, the chairman of the HELP Committee, the majority leader and their staffs for helping us work through this package, and I look forward to its adoption.

With that, I yield the floor, and I believe the junior Senator from Colorado will speak next.

The ACTING PRESIDENT pro tempore. The Senator from Colorado is recognized.

Mr. BENNET. Mr. President, I wish to thank our colleague from Virginia, Senator WARNER, for his extraordinary leadership throughout this process of the freshmen coming together to see what we can do to move this legislation forward to improve it. I think a lot has been said about how the bill that was drafted by the HELP Committee, by the Finance Committee, and now by the majority leader is directionally correct in its efforts to get a handle on these skyrocketing costs. I think this amendment package will move us much further in the right direction of trying to hold down costs for our working families and small businesses across the country.

Throughout this entire debate and going back to the very beginning, what I have said is, no matter where you are on many of the issues, there can't be any disagreement that the current system, with respect to costs, is completely insane. Our families in Colorado faced double-digit cost increases every year over the last decade. Their median family income has actually gone down by \$300, and the cost of health care has gone up by 97 percent over that period of time. Our small businesses are paying 18 percent more for health insurance than large businesses just because they are small. As the Senator from Virginia was mentioning, we are spending, as a country, more than twice what almost any other industrialized country in the world is spending as a percentage of our gross domestic product on health care. We are spending roughly 18 percent, going to 20 percent in the blink of

an eye. We can't hope to compete in this global economy if we are devoting a fifth of our economy to health care and everyone else in the world is devoting less than half that. Finally, as the Senator from Virginia also said, if you have any concern about these deficits we are facing in Washington becoming completely untenable, what you need to know is, the biggest driver of those is rising Medicare and Medicaid costs and the biggest driver of those is, of course, health care costs.

So my view has been, from the start, no matter what your entry point was into this debate, cost was the central question for our working families and for our small businesses. We have stressed the need over and over for health care reform to contain the rising costs that are plaguing our current system. That is why I think the Senate needs to adopt the freshman amendment package, which would cut costs, save taxpayers money, and in this bill it can make our health care system function more efficiently.

This package of amendments will help strengthen the reform proposal's ability to deliver affordable, quality health care to all Americans, whether they are in private plans or whether they are in public plans. These provisions will remove much of the redtape that, for so long, has slowed the delivery of care. Doctors from all over Colorado have told me, time and time again, their medical practices are mired in paperwork and their staffs spend far too much time and money jumping through administrative hoop after hoop. The time our doctors and nurses spend on unnecessary paperwork is time they can't spend becoming better professionals and, most importantly, providing quality care to their patients. This amendment will require the Secretary of Health and Human Services to adopt and regularly update a single national standard for some of the most basic electronic transactions that occur between insurers and providers, and meeting these standards will be enforceable by penalties if insurance providers don't take steps to comply. My provision will make sure that as we implement health care reform, we are consistently identifying and implementing new standards.

There are also terrible inefficiencies in the way we pay health care providers and allow them to deliver care to patients. This package helps eliminate bottlenecks so patients are cared for in a reasonable amount of time.

This package of amendments also expands the Senate bills reforms being made to Medicare and Medicaid. There is a provision that will allow accountable care organizations to work with private insurance companies to better craft strategies for Medicare and Medicaid and private sector plans to improve care. In the current system, doctors are forced into requesting a multitude of tests to confirm a diagnosis they have already made. This creates

unnecessary work for doctors, their administrative staffs, lab technicians, and so on. It is time we create a system that empowers doctors to practice medicine and do their jobs efficiently.

Under the current broken system, doctors have to endure needless hurdles to even set up a practice. It is no wonder the number of primary care doctors has been steadily declining for some time now.

This package of amendments would create an environment that attracts doctors back to the field rather than make it more difficult for them to provide care. Along with the savings this bill already creates, these amendments will help doctors remove the redtape that has limited their ability to help patients in a timely manner.

We cannot go on allowing the middle class to absorb the rising costs of our Nation's health care system. We need health care reform that will control costs and put us back on a path toward fiscal responsibility. This package of amendments will help us do that.

I wish to, again, say thank you to my colleagues from the freshman class for their work. This sometimes has seemed tedious and sometimes hard to describe, but these amendments are very critical if we are going to get hold of costs as we go forward. That is the relief working families in this country need more than anything. In order to have stability in their lives, we have to get hold of our rising health care costs.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts is recognized.

Mr. KIRK. Thank you, Mr. President.

With great joy and enthusiasm, I can say that today we are closer than ever to guaranteeing that all Americans, at long last, will have full access to quality, affordable health care. The Patient Protection and Affordable Care Act, which our colleague and fellow freshman Senator JEFF MERKLEY of Oregon suggests, as Senator Kennedy of Massachusetts would have subscribed to, that this is the health care bill of rights. It will help fix a health care system that is failing to meet the needs of the American people. I am extremely proud to join with Majority Leader REID, with Senator BAUCUS, with my good friend, Senator DODD of Connecticut, and with my fellow freshman Senators. I wish to single out, if I may, the Senator from Virginia, MARK WARNER, one of the more enlightened business leaders of our time, who brought his wisdom and innovation and skills and practices of the private sector to help improve the important challenge we have in the public sector. I thank the Senator for his leadership on this effort, in contributing to legislation that will mark a historic stride forward for the American people.

I wish to say a word as well, a particular word, about the chairman of the Finance Committee who has enormous responsibilities in the Senate chairing the effort to reform our finan-

cial regulations and our financial systems so the American people will understand we are one country, with one important financial system and not somehow second tier, unrelated and unconnected to the decisions made on Wall Street and elsewhere. When Senator Kennedy of Massachusetts was stricken, Senator DODD of Connecticut stepped forward, not only because Senator Kennedy was his very close friend but because the Senator from Connecticut understood the enormity of the challenge and important effort that is being made in the Senate. I wish to salute him for sharing his wisdom and his strength and his leadership, not only in the areas of financial reform but in this important area as well.

As I said, this is nothing less than a bill of rights for the American people on the issues of health care. With this legislation, all Americans, finally, will be guaranteed access to the affordable health care coverage they deserve. Families who need a helping hand to care for an aging relative will be protected. Insurance companies will be prohibited from arbitrarily refusing coverage and from stopping benefits when they are needed the most. Doctors will be given the support they need to practice the best medicine possible. That is why they took their oath. With the help of the measures in this total legislation and some of the particular reforms suggested by our freshman colleagues, that best medicine will be practiced. The American economy will be protected from the skyrocketing costs of health care, with which every American family is now inflicted.

Over the past month, I have had the privilege of working with my fellow freshman colleagues on a series of amendments that we are discussing this morning to make this health care bill of rights even stronger. These amendments plant the seed for an innovative 21st-century health care system that offers what American families want most: better results for lower costs. It is as simple as that. These amendments focus on the root causes of our skyrocketing health care costs to provide Medicare the support it needs to become a leader in moving away from the reimbursement models that increase costs without improving care.

Public-private arrangements will be established to smooth reform and prevent private insurance from shifting costs onto public plans. The redtape, with which we are all familiar, which weighs down the current health care system in both the public and private sectors will be reduced. All of this will contribute to lower costs and higher quality in our health care system.

One focus that is particularly of interest and important to me is the delivery system reform. We must move toward a system of paying hospitals and doctors for the quality of care they provide rather than the quantity of tests and procedures they perform. Our

amendment rewards providers of Medicare who give high-quality care rather than high-volume procedures. We will also allow Medicare to test promising new models to reduce costs, increase quality, and improve patient health. We must make these changes for the sake of our patients and for the sake of our economy.

In short, our amendments strengthen the reforms of the Patient Protection and Affordable Care Act. I urge all my colleagues to support these amendments and take these important steps with us to bring America's health care system into the 21st century.

I thank the leadership once again, and I thank the Senator from Virginia and my other freshman colleagues for their good work on this historic health care bill of rights.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Colorado is recognized.

Mr. UDALL of Colorado. Mr. President, my freshman colleagues and I have come to the floor on a regular basis over the last few months to make clear to both sides of the aisle just how critical it is that we succeed in reforming our health care insurance system.

Right now, too many Americans lack the freedom to move to a new job, further their education, or start a small business because doing so can put them at risk of losing health care coverage for their family. If you think about it, freedom is, after all, about choices. What motivates me—and I know it motivates my freshman colleagues—is the desire to preserve and enhance the freedom of all Americans.

This legislation we have been debating and amending over the past 2 weeks can and should be a vehicle that we use to enhance freedom for all of our American citizens. We are going to repair and modernize a broken health care system. If we fail to do so, we perpetuate an antiquated status quo that stalls economic growth, stifle the entrepreneurs who make up the American business landscape, and keep stability and security out of reach for millions of American families.

The package of amendments we present today is designed to inject more cost containment into the bill, cut down on regulatory and bureaucratic redtape, and push us more aggressively toward a reformed health care system that rewards better patient care rather than simply more care.

In developing these ideas, my fellow freshmen and I have relied upon the input of people back home. And through my discussions with constituents, health care providers, and businesses from all over Colorado, a common theme has emerged: They want a health care system that tackles costs, while keeping the focus on patients and quality. I believe we have accomplished that with our freshman proposal because more than 30 groups have come out in the past few days in support of

our efforts. This is a wide-ranging number of groups, including consumer champions such as AARP, business leaders such as the Business Roundtable, and health providers such as Denver Health in my home State.

My freshman colleagues have spoken about individual pieces of this effort that combine to make the whole. I will single out a section that I think will have a particularly strong influence on the future of our health care system.

Senator ROCKEFELLER has authored an important provision that creates the independent Medicare advisory board. This board would be tasked with keeping down the costs in the Medicare system by issuing proposals to cut spending and increase the quality of care for beneficiaries.

I applaud this contribution to the bill, but I have wondered why we cannot take it a step further by looking at the whole health care system and not just Medicare in isolation. If we are going to tackle spiraling health costs across the country, we need to push each area of our health care system to be smarter and more efficient in dealing with cost growth.

One of my contributions to the package is a provision to expand the scope of the Medicare advisory board to examine not just Medicare but the entire health care system and task the board with finding ways to slow down the growth of health costs across the country. This would include providing recommendations on the steps the private sector should take to make our delivery system more efficient. Health care leaders and economists agree that such an approach can help push our system toward a more streamlined and coordinated way of delivering health care to all Americans.

In sum, I thank the Senator from Virginia for his leadership, the Senator from Oregon, Mr. MERKLEY, and Senator SHAHEEN from New Hampshire. It has been a delight to work with 11 of my fellow Senators. This is a bold contribution to the package that I know we will pass out of the Senate. We come from varying parts of the country and have varied political outlooks and backgrounds. This will attract broad support in our Chamber. It is a winning addition to health care reform, and I encourage all Senators to support our efforts.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from New Hampshire is recognized.

Mrs. SHAHEEN. Mr. President, I am so pleased this morning to join my freshman colleagues in introducing our innovation and value package.

For the last several months, the freshmen in the Senate have been coming to the floor to help make the case for health care reform, to tell our colleagues and the public about what we have heard from our constituents, and to come together as one voice in support of reform.

Today, we back up that rhetoric with action. Today, we propose something

concrete. We have talked about the importance of reforming the way we deliver care, about how we need to slow down the skyrocketing costs of health care, while improving quality, and about the need to provide incentives to make the changes happen. Today, we deliver on that talk. Our proposals are about containing costs, about looking into the future, thinking about our delivery system, and finding ways to make small but very important changes that will make a difference.

Throughout this debate, I have been talking about the importance of increasing the quality of care while reducing the cost. This amendment package does just that.

This amendment package matters. It matters to all the health care consumers who are interested in reducing costs and increasing the value in our health care system. It especially matters to business. The high cost of health care and insurance coverage eats away at the bottom line for businesses. If we can reduce waste and inefficiency, attack fraud, and simplify our system, we can reduce costs. The innovations in this package attract business because business understands that we need to take steps in our public and private health care systems to lower costs and deliver value.

I am proud that, with this amendment, we are able to promote the good work of Elliot Fisher and his colleagues at the Dartmouth Institute for Health Policy and Clinical Practice and to recognize the work they have done on accountable care organizations.

Accountable care organizations are about coordinating care among providers—hospitals, primary care physicians, specialists, and other medical professionals. These accountable care organizations make decisions with patients. I think that is the operative phrase. They make decisions “with” patients about what steps they can take together to improve care. When these efforts result in cost and quality improvements, providers and consumers can share in the savings. This is the essence of true reform. We must demand performance, quality, and value from our health care system. This package makes great strides.

I will close by thanking all of my fellow freshmen. I am so proud to be part of this freshman class and all of the great work they have done.

I especially wish to recognize Senator WARNER, who has really been the driving force behind this health care package. I am not sure I agree with his cell phone analysis, but I certainly agree with the leadership he has shown on this package.

Also, I recognize our senior colleagues, Senators DODD, BAUCUS, REID, and HARKIN, for the leadership they have shown in getting us to this point.

Finally, I recognize all of the staff of all of us freshman Senators, many of whom are here today, who have worked so hard to get us to this point. I single

out my assistants, Alison MacDonald and Dr. Manny Jimenez, for the work they have done on this package. It is a great effort, and I am pleased to be here with my fellow freshmen.

I urge all of our colleagues to join us in support of this effort.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina is recognized.

Mrs. HAGAN. Mr. President, I rise in support of the freshman value and innovation package, which builds on efforts to provide quality, affordable health care at a lower cost to families. I, too, applaud our colleague, Senator MARK WARNER, for helping to initiate this package.

I wish to take a moment to talk about two provisions in the package that I included: curbing fraud and abuse with 21st-century technology and medication therapy management.

Today, Medicare spends about \$430 billion annually; Medicaid, approximately \$340 billion; the States Children's Health Insurance Program, an additional \$5 billion, for a total of \$775 billion.

In Medicare alone, annual waste amounts to between \$23 billion and \$78 billion. Yet, despite these sky-high numbers, investigations are pursued only after payment has been made, which means government fraud investigators have to recover funds that have already been paid. As a result, it is estimated that only about 10 percent of possible fraud is ever detected, and of that amount only about 3 percent is ever actually recovered. This means the government recovers, at best, about \$130 million in Medicare waste, fraud, and abuse. Again, when estimates are between \$23 billion and \$78 billion, we are only recovering \$130 million.

“Doctor shopping” is an example that was profiled in a recent USA TODAY news article and GAO report. This involves a patient receiving multiple prescriptions from numerous doctors in a short period of time, without getting caught. Each of the claims gets paid by Medicare, Medicaid, or even private health insurers.

The current technology exists to assess in real time if a claim warrants further investigation, and this technology will prevent fraudulent claims from being paid on the front end. A software company in Cary, NC, SAS, has developed this technology.

This amendment will require the Department of Health and Human Services to put into place systems that will detect patterns of fraud and abuse before any money leaves our Federal coffers.

Another source of waste in the system is people not sticking to their medication regimen. As much as one-half of all patients in our country do not follow their doctors' orders regarding their medications. The New England Health Care Institute estimates that the overall cost of people not following directions is as much as \$290 billion per year.

This waste can be eliminated with medication therapy management. That is a program where seniors bring all of their prescriptions, in a little brown bag, and their over-the-counter medications and their vitamins and supplements to the pharmacy to be thoroughly reviewed in a one-on-one session. The pharmacist follows up and educates the patient about his or her medication regimen.

North Carolina has some successful medication therapy management programs already in place.

In 2007, the North Carolina Health and Wellness Trust Fund Commission launched an innovative statewide program called Checkmeds NC to provide medication therapy management services to our seniors. During the program's first year, more than 15,000 seniors and 285 pharmacists participated. Just this small program saved an estimated \$10 million, and countless health problems were avoided for our seniors.

This amendment takes this successful North Carolina model and implements it nationally, permitting pharmacies and other health care providers to spend considerable time and resources evaluating a person's drug routine and educating them on proper usage.

I urge passage of this freshman amendment package which will further reduce health care costs for American families. Thank you.

Mr. UDALL of New Mexico. Madam President, I seek recognition.

The PRESIDING OFFICER (Mrs. GILLIBRAND). The Senator from New Mexico.

Mr. UDALL of New Mexico. Madam President, this package today is a result of collaboration that began months ago when the Senate's freshman class united as advocates for comprehensive health reform, when we united in the belief that the status quo is not an option.

The health care status quo does not work for Americans and it does not work for America either. If we fail to act, every person, every institution, every small business in this country will pay the price.

Achieving true reform means making insurance available and affordable to all Americans. It also means reining in out-of-control spending. For some, those two goals seem diametrically opposed. They ask: How can you contain costs when you are expanding access to millions of additional people?

One of our country's great economic thinkers, Paul Krugman, recently challenged this hypothesis. First, he said a majority of Americans uninsured are young and healthy. Covering them would not increase costs very much. Second, he noted that this reform links coverage expansion to "serious cost-control measures."

These goals are two sides of the same coin. Without one, we cannot have the other. As Mr. Krugman said:

The path to cost control runs through universality. We can only tackle out-of-control

costs as part of a deal that also provides Americans with the security of guaranteed health care.

With these amendments, we take additional steps to transform our delivery system, to contain costs, and to curb abuses and excess spending. With these amendments, we encourage a faster transition to a 21st-century system that is more efficient, costs less, and holds providers and insurers accountable.

I am proud to sign on to all of the amendments in this package. But there is one proposal that is particularly important to the people of New Mexico. In my State, 30 of 33 counties are classified as medically underserved. Residents of these highly rural counties are more likely to be uninsured. They are more likely to have higher rates of disease. And because of a shortage in health care providers, they are often forced to travel long distances for care.

This amendment would help us take the first steps toward alleviating the growing shortage of primary care physicians in New Mexico and across the country. By 2025, there will be a shortage of at least 35,000 primary care physicians in the United States. As this shortage grows, our rural areas will be hardest hit.

In this amendment, we call for expert recommendations on how to encourage providers to choose primary care and to establish their practices in medically underserved areas. These experts would analyze things such as compensation and work environment. They would recommend ways to increase interest in primary care as a career.

We are closer than ever to providing all Americans with access to quality, affordable health care. I am proud to be a part of a group of freshmen who refuse to sit on the back bench and watch this reform develop from the sidelines. I am proud to be part of a group that from the beginning refused to accept the status quo as an option.

I thank the staff of all these fine Senators and thank personally my staff members, Fern Goodheart and Ben Nathanson.

I look forward to continuing the work with this outstanding group as we debate a bill that will improve our health care system for generations to come.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. BURRIS. Madam President, it is also my pleasure to stand with my colleagues and be a part of this health reform package, to give recognition to those distinguished senior Senators who have put so much heart into drafting this important legislation, to our Leader REID and to Senator BAUCUS, Senator DODD, and all the individuals. It is a pleasure for me to be a part of this freshman colloquy on this major package.

Over the past several months, my freshman colleagues and I have taken the floor many times to speak about

the need for comprehensive health care reform. I am pleased to join them today as we discuss our cost containment package.

This set of provisions will help promote accountability, increase efficiency, and reduce disparities in our health care system. Our amendment will reinforce and improve the principles of high-value, low-cost care that is central to the Patient Protection and Affordable Care Act.

Our amendment will strengthen Medicare's ability to act as a payment innovator, paying for value and not for volume. In speeding this process, our amendment gives Medicare more of the resources it needs to gather data, expand programs that work, and reach the neediest patients.

We also work to strengthen waste, fraud, and abuse provisions in the Patient Protection and Affordable Care Act in order to make sure that the Department of Health and Human Services has the tools to not only punish offenders but to prevent fraud from happening in the first place.

But this is not just about our public programs. We also promote private-public data sharing to get a better picture of our whole medical system.

Our amendment further takes aim at administrative costs, another barrier often cited to getting the most effective care, by encouraging public-private collaboration to create uniform standards and reduce the mountain of paperwork that takes doctors' time away from their patients.

Finally, we put pressure on private insurers to change the way they pay. By encouraging insurers to reward programs that reduce disparities, providers will increasingly focus attention on populations that need it most.

By proactively targeting these needy folks through cultural competency training, language services, and community outreach, our amendment will increase wellness and reduce the use of costly emergency room care.

My colleagues and I are supported by top business groups, consumer groups, and providers because they all know we have to transform the way care is delivered in this country. Businesses know that without the reduced cost of care and promoting transparency, the cost of premiums continues to rise, putting a stranglehold on wage increases and making them less competitive.

Consumer groups want to ensure the patients get more value for their dollar, that they do not just get more care but they get the type of coordinated, effective care that will keep them healthy and out of the emergency rooms. Those providers who focus on targeted care to get the best patient outcome want to be rewarded for doing so.

The evidence could not be clearer, the conclusions could not be more decisive that the Patient Protection and Affordable Care Act, coupled with our amendment, will lower costs for ordinary Americans.

I call upon my colleagues to take an honest look at what we are doing, and I defy them to say that health care reform will not reduce costs and improve the functioning of our health care system.

The debate over health care reform cannot be scoring political points. It must be about the health and well-being of the American people. All of our great work will bear fruit, and we will reform our Nation's health system because there is no other option. Our citizens demand it, and they deserve no less.

I thank our distinguished colleagues. I am happy to be a part of this freshman colloquy in presenting such an important issue at this time in history in this great country of ours.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. BEGICH. Madam President, I seek the floor to talk about this package of cost containment offered by the freshmen. I am proud to join them in offering this amendment today.

The technical work in this package is complex and complicated, but the themes it addresses are simple and straightforward, which I know our colleagues on the other side will appreciate and we hope support—value, innovation, quality, transparency, and cost containment.

The full legislation now under debate in the Senate makes wonderful strides in fixing what is broken in America's current health care system. Under the leadership of Senators BAUCUS, DODD, HARKIN, and our Majority Leader REID, the committees have done incredible work.

What the freshmen are saying today is we believe our package can help. We can go further. We can do better. Our goal is a health care system that is more efficient and more affordable.

In a few moments, I will stand together at a news conference with all my freshman colleagues to formally announce this package. What I most appreciate is that we will do so with the support of consumer and business groups.

While the language of this amendment promotes efficiency and encourages innovation within the health delivery system, what it is about is helping individual Americans and businesses get a better deal on health care. I am proud of that, especially when we know that cost containment is the No. 1 priority of small business owners in this health reform debate.

Insurance premiums alone in the last 10 years for small businesses have risen 113 percent. It was reported in the media that small businesses in this country face another 15-percent increase in the health premiums in the coming year.

What about families, our friends, and our neighbors? Health insurance premiums are eating up ever growing chunks of the family budget. Nationwide, family health insurance pur-

chased through an employer at the start of this decade cost about \$6,700, almost 14 percent of the family income. Last year, the same premium cost \$13,000—21 percent of the family income.

If we do nothing, if we do not reform the system and do not contain costs, this country will be in big trouble. By 2016, the same family health insurance will cost more than \$24,000. Because health costs are skyrocketing compared to wages, that \$24,000 will represent 45 percent of the family budget. Enough is enough. The package we are offering today will help.

I want to focus briefly on a small but significant piece of this package that addresses rural health care. It will help hospitals in several States, including Alaska, my home State, by extending the Rural Community Hospital Demonstration Program. We are building on known success. The program is small. Even with this amendment, the number of eligible hospitals nationwide will expand from 15 to 30, and 20 rural States will be eligible to participate instead of the current 10.

Part of what we are saying in this package is this: If something is working to provide better health care access and value, for goodness sake, let's keep it going and do what we can to improve on it.

My thanks go to Senator BEN NELSON who has been a champion of this program and is also pushing for the extension.

As I conclude, I wish to stress once again how proud I am to stand with my freshman colleagues. The cost containment package we are proposing today will help all Americans, and I hope it will move the Senate that much closer to a historic vote on the landmark legislation that is before us today.

I yield the floor.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. WARNER. Madam President, I know our time is about to expire. I wish to close by thanking all my freshman colleagues and their staffs for the great work they have done on this legislation.

I see a number of my colleagues from the other side of the aisle. This is an amendment package that brings greater transparency, greater accountability, greater efficiency, and greater innovation, and is supported by the Business Roundtable, small businesses and health care systems around the country. I ask for their consideration.

I again thank the Chair, Senator DODD, for allowing us to lay out this package of amendments. I think it will add an important component to this bill in trying to rein in costs not just on the government side but system-wide.

I yield the floor.

Mr. DODD. Madam President, quickly, because I know my colleagues are here on the other side, I want to commend 10 of the 11 new freshmen who are here and who have spoken with great

eloquence and passion about this issue. I think all of us, regardless of which side of the aisle we are on, owe them all a great deal of gratitude for putting together a very fine package.

I particularly thank Senator MARK WARNER, our colleague from Virginia, who has led this effort, but obviously so much of this has happened because of the cooperation and ideas that each Member who has spoken here this morning has brought to this particular cluster of ideas on cost containment. All Americans owe them a deep debt of gratitude and can feel pretty good about the future of our country with this fine group of Americans leading it.

The PRESIDING OFFICER. The minority now has 60 minutes.

Mr. BAUCUS. Madam President, may I ask unanimous consent to speak for a couple of minutes to comment on the freshman package? It will just take a few minutes.

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

Mr. BAUCUS. Madam President, I join my good friend from Connecticut in thanking—I don't know if calling them freshmen would be wise, because our colleagues act as though they have been here for years and know the subject extremely well.

Delivery system reform has always been something I have been pushing for, and I am happy to see it is part of your package, and also with additional emphasis on rural areas and Indian reservations. We clearly need more of that, and more transparency. I firmly believe that will help us get costs down and get quality of care up. Your work on the independent Medicare advisory board is great too.

To be honest, these are all the next steps in ideas that are pretty much in the bill, but they are the proper next steps, and the next steps I firmly believe should be taken. So I compliment you and thank you very much, and I thank my friend from Arizona for allowing me this time.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Madam President, I wish also to add my words of congratulations to the new Members for their eloquence, their passion, and their well-informed arguments, although they are badly misguided. But I do congratulate them for bringing forth their ideas and taking part in this spirited debate. We welcome it, and I hope that someday we will be able to agree on both sides for us to engage in real colloquy between us, back and forth. I think the American people and all Members would be well informed.

Madam President, I ask unanimous consent for the next 30 minutes to engage in a colloquy with my colleagues.

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

Mr. MCCAIN. Madam President, I talk a lot about C-SPAN. I am a great admirer of C-SPAN. And the President—at least when he was running for the presidency—believed in C-SPAN as

well, because he said C-SPAN would be in on the negotiations. Here is what was posted by a reporter from Politico last night at 5:48 p.m., entitled "No C-SPAN Here."

Right now a group of moderate Senators is meeting behind closed doors to try to hash out a compromise on the public option. Reporters, waiting for the meeting to break, were just moved out of the corridor nearest the meeting and shunted around the corner, making it harder for the press to catch Senators as they leave. C-SPAN this is not.

I would remind my colleagues that the amendment we are discussing here is drafted to prevent drastic Medicare Advantage cuts from impacting all seniors in Medicare Advantage. The amendment says simply: Let's give seniors who are members of Medicare, who have enrolled in Medicare Advantage, the same deal that Senator NELSON was able to get for the State of Florida—at least most of the seniors who enrolled in the Medicare Advantage Program. There are 11 million American seniors who are enrolled in the Medicare Advantage Program. This amendment would allow all 11 million to have the same benefits and there would be no carve-out for various groups of seniors because of the influence of a Member of this body.

I want to quote again the New York Times, my favorite source of information, from an article entitled "Senator Tries to Allay Fears on Health Overhaul."

... Mr. Nelson, a Democrat, has a big problem. The bill taken up this week by the committee would cut Medicare payments to insurance companies that care for more than 10 million older Americans, including nearly one million in Florida. The program, known as Medicare Advantage, is popular—

And the article lists the benefits, and then continues as follows:

"It would be intolerable to ask senior citizens to give up substantial health benefits they are enjoying under Medicare," said Mr. Nelson, who has been deluged with calls and complaints from constituents. "I am offering an amendment to shield seniors from those benefit cuts."

He is offering an amendment to shield senior citizens. Well, I am offering a motion that deals with all of the 11 million seniors who are under Medicare Advantage, as the Senator from Florida said, to shield seniors from benefit cuts. That is what this motion is all about. We should not carve out for some seniors what other seniors are not entitled to. That is not America. That is not the way we should treat all of our citizens, and I hope my colleagues will understand this amendment is proposed simply in the name of fairness.

I ask the Senator from Tennessee and the Senator from Texas, who have a large number of enrollees in the Medicare Advantage Program, whether they feel this would be unfair?

Mr. ALEXANDER. Well, I thank the Senator from Arizona for his motion, and I thank the Senator from Florida for his amendment, because Medicare Advantage is very important to Ten-

nesseans. We have 243,000 Tennesseans who have opted for Medicare Advantage. About one-fourth of all Americans who are on Medicare have chosen Medicare Advantage because it provides the option for increased dental care, for vision care, for hearing coverage, for reduced hospital deductibles, and many benefits. It is helpful to low-income and minority Americans, and it is especially helpful to people in rural areas.

What the Republicans have been arguing all week is that, contrary to what our friends on the other side are saying, this bill cuts those Medicare Advantage benefits. The Director of the Congressional Budget Office says that fully half—fully half—of the benefits in Medicare Advantage for these 11 million Americans will be cut. Our Democratic friends say: No, that is not true. That is not true. We are going to cut \$1 trillion out of Medicare over a fully implemented 10-year period of this bill, but nobody will be affected by it.

Well, the Senator from Florida apparently doesn't believe that. He says: We have 900,000 Floridians who don't want their Medicare Advantage cut. And he is saying, in effect, we don't trust this Democratic bill to protect these seniors in Medicare Advantage.

So I ask the Senator from Texas: If the people of Florida and the Senator from Florida don't trust the Democratic bill to protect Medicare Advantage, why should 240,000 Tennesseans trust the Democratic bill to protect Medicare Advantage?

Mr. CORNYN. I agree with the distinguished Senators from Tennessee and Arizona, that what is good enough for the seniors in Florida ought to be good enough for all seniors. In my State of Texas, we have 532,000 seniors on Medicare Advantage, and they like it, for the reasons that the Senator from Tennessee mentioned. They do not want us cutting those benefits.

But I say to the Senators from Arizona and Tennessee, I seem to recall that we had amendments earlier which would have protected everybody from cuts in Medicare benefits, and now we have a targeted effort, negotiated behind closed doors, to protect States such as Florida and Pennsylvania and others, and I wonder whether the Nelson amendment to protect the seniors of Florida would even be necessary if our colleagues across the aisle had agreed with us that no Medicare benefits should be cut.

Mr. MCCAIN. As the Senator points out, a few days ago, by a vote of 100 to 1, we voted to pass an amendment proposed by the Senator from Colorado, Senator BENNET, which included words such as "protecting guaranteed Medicare benefits" or "protecting and improving guaranteed Medicare benefits." The wording was: "Nothing in the provisions of or amendments made by this act shall result in the reduction of guaranteed benefits under title XVIII of the Social Security Act."

Is there any Member on the other side who can guarantee that seniors in his or her State in Medicare Advantage will not lose a single benefit they have today—not the guaranteed benefit the other side goes to great pains to talk about. I think those who are enrolled in the Medicare Advantage system believe that since they receive those benefits, they are guaranteed benefits as well.

I would ask our two physicians here on the floor, who both have had the opportunity to deal directly with the Medicare Advantage Program, if you have a patient come in and you say: By the way, you are having your Medicare Advantage Program cut, but don't worry, we are protecting your guaranteed Medicare benefits, do you think they understand that language?

Mr. COBURN. I would respond to the Senator from Arizona in the following way. First of all, they won't understand that language. But more importantly, if you look at the law, there is Medicare Part A, Medicare Part B, Medicare Part C, and Medicare Part D. They are all law. They are all law. What is guaranteed under the law today is that if you want Medicare Advantage, you can have it. What is going to change is that we are going to take away that guarantee. We are going to modify Medicare Part C, which is Medicare Advantage.

So we have this confusing way of saying we are not taking away any of your guaranteed benefits, but in fact, under the current law today, Medicare Advantage is guaranteed to anybody who wants to sign up for it. So it is duplicitous to say we are not cutting your benefits, when in fact we are.

Let me speak to my experience and then I will yield to my colleague from Wyoming, who is an orthopedic surgeon.

What is good about Medicare Advantage? We hear it is a money pot to pay for a new program for other people. Here is what is good about it. We get coordinated care for poor Medicare folks. Medicare Advantage coordinates the care. When you coordinate care, what you do is you decrease the number of tests, you prevent hospitalizations, you get better outcomes, and consequently you have healthier seniors.

So when it is looked at, Medicare Advantage doesn't cost more. It actually saves Medicare money on an individual basis. Because if you forgo the interests of a hospital, where you start incurring costs, what you have done is saved the Medicare Trust Fund but you have also given better care.

The second point I wish to make is that many people on Medicare Advantage cannot afford to buy Medicare supplemental policies. Ninety-four percent of the people in this country who are on Medicare and not Medicare Advantage are buying a supplemental policy. Why is that? Because the basic underlying benefit package of Medicare is not adequate. So here we have this

group of people who are benefitted because they have chosen a guaranteed benefit of Medicare Part C, and all of a sudden we are saying: Time out. You don't get that anymore.

Mr. MCCAIN. So a preponderance of people who enroll in Medicare Advantage are low-income people, and a lot of them are rural residents?

Mr. COBURN. A lot of them are rural. I don't know the income levels, but I know there is a propensity for actually getting a savings, because you don't have to buy a supplemental policy if you are on Medicare Advantage.

Mr. BARRASSO. I would add to that, following on my colleague from Oklahoma, that there is the coordinated care, which is one of the advantages of Medicare Advantage, but there is also the preventive component of this. We talk about ways to help people keep their health care costs down, and that has to do with coordinated care and preventing illness.

Mr. COBURN. And we heard from the freshman Democrats that they want to put a new preventive package into the program. Yet they want to take the preventive package out of Medicare Advantage. It is an interesting mix of amendments, isn't it?

Mr. BARRASSO. We want to keep our seniors healthy. That is one way they can stay out of the hospital, out of the nursing home, and stay active. Yet with the cuts in Medicare Advantage, the Democrats have voted to do that—to cut all the money out of this program that seniors like. Eleven million American seniors who depend upon Medicare for their health care choose this because there is an advantage to them.

My colleague from Oklahoma, the other physician in the Senate, has talked, as I have, extensively about patient-centered health care—not insurance centered, not government centered. Medicare Advantage helps keep it patient centered. So when I see deals being cut behind closed doors where they are cutting out people from all across the country and providing sweetheart deals to help seniors on Medicare Advantage in Florida in order to encourage one Member of the Senate to vote a certain way, I have to ask myself: What about the seniors in the rest of the country, whether it is Texas, Oklahoma, Tennessee, or Arizona?

A lot of seniors have great concern, and I would hope they would call up and say this is wrong; we need to know what is going on, and to ask why it is there is a sweetheart deal for one se-

lected Senator from one State when we want to have that same advantage; and why are the Democrats voting to eliminate all this Medicare money.

Mr. CORNYN. May I ask my colleagues a question—maybe starting with the Senator from Arizona—on a related issue. Medicare Advantage is a private sector alternative or choice to Medicare, which is a government-run program. I am detecting throughout all of this bill sort of a bias against the private sector and wanting to eliminate choices that aren't government-run plans.

Am I reading too much into this or do any of my colleagues see a similar propensity in this bill?

Mr. ALEXANDER. If I may respond to the Senator from Texas, I think he is exactly right. There is a lot of very appealing talk that we hear from the advocates of the so-called health reform bill. But when we get right down to it, and when we examine it closely, we find a big increase in government-run programs. What does that mean for low-income Americans, and what does it mean for seniors who depend on our biggest government-run programs, Medicare and Medicaid? It means they risk not having access to the doctor they want. The Senator from Wyoming mentioned the Mayo Clinic, widely cited by the President and by many on the other side as an example of controlling costs, is beginning to say: We can't take patients from the government-run programs in some cases because we are not reimbursed properly.

What is going to happen behind all this happy talk we are hearing about health care is, we are going to find more and more low-income patients dumped into a program called Medicaid. Under this program half the doctors will not see a new Medicaid patient. It is akin to giving someone a bus ticket on a bus line that runs half the time. Medicare is going to increasingly find itself in the same shape as Medicaid. The Mayo Clinic has already said they can't afford to serve patients from the government-run programs. The Senator from Texas is exactly right. We don't have to persuade the 11 million Americans who have chosen Medicare Advantage that it is a good program. They like it. In rural areas, between 2003 and 2007, more than 600,000 people signed up for it. In a way, the Senator from Florida may have a sweetheart deal, but in a way he has done us a favor. We have been trying to say all week the Democrats are cutting Medicare. They are saying: Trust us, we are not cutting Medicare. The Sen-

ator from Florida is saying: Floridians don't trust you. You are cutting their Medicare Advantage. I want to have an amendment to protect them. Senator MCCAIN is saying: Let's protect all seniors' Medicare Advantage.

Mr. MCCAIN. May I also point out, for the record, on September 20, 2003, there was a letter to the conferees of Medicare, urging them to include a meaningful increase in Medicare Advantage funding for fiscal years 2004–2005—a group of 18 Senators, including Senators SCHUMER, LAUTENBERG, CLINTON, WYDEN, et cetera, including Senator KERRY, who now obviously wants to reduce the funding for Medicare Advantage. Again, perhaps he was for it before he was against it.

I would also like to point out, as short a time ago as April 3, 2009, a group of Senators, bipartisan, including Senators WYDEN, MURRAY, SPECTER, BENNET, KLOBUCHAR, and others, wrote to Charlene Frizzera, acting administrator of the Centers for Medicare and Medicaid Services:

We write to express our concerns regarding the Centers for Medicare and Medicaid Services' proposed changes to Medicare Advantage rates for calendar year 2010. The advance notice has raised two important issues that, if implemented, would result in highly problematic premium increases and benefit reductions for Medicare Advantage enrollees across the country.

Again, as recently as last April, there was concern on the other side about cuts in the Medicare Advantage Program.

Mr. COBURN. I wonder if the Senator is aware, in Alabama, there will be 181,000 people who will get a Medicare Advantage cut; in California, 1,606,000 seniors are going to have benefits cut; Colorado, 198,000; Georgia, 176,000; Illinois, 176,000; Indiana, 148,000; Kentucky, 110,000; Louisiana, 151,000; Massachusetts, 200,000; Michigan, 406,000—that is exactly what Michigan needs right now, isn't it, for their seniors to have their benefits cut—Minnesota, 284,000; Missouri, 200,000; Nevada, 104,000; New Jersey, 156,000; New York, 853,000; Ohio, 499,000; Oregon, 250,000; Pennsylvania—maybe, maybe not because they may have the deal—865,000; Tennessee, 233,000; Washington State, 225,000; Wisconsin, 243,000.

I ask unanimous consent that the list of what the enrollment is by CMS on Medicare and Medicare Advantage enrollment, as of August 2009, be printed in the RECORD.

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

State	MA Enrollment (August 2009)	Eligibles	MA Penetration (percent)
Alabama	181,304	819,112	22.1
Alaska	462	61,599	0.8
Arizona	329,157	876,944	37.5
Arkansas	70,137	515,175	13.6
California	1,606,193	4,562,728	35.2
Colorado	198,521	591,148	33.6
Connecticut	94,181	553,528	17.0
Delaware	6,661	142,716	4.7
DC	7,976	75,783	10.5

State	MA Enrollment (August 2009)	Eligibles	MA Penetration (percent)
Florida	946,836	3,239,150	29.2
Georgia	176,090	1,176,917	15.0
Hawaii	79,386	197,660	40.2
Idaho	60,676	218,225	27.8
Illinois	176,395	1,792,581	9.8
Indiana	148,174	973,732	15.2
Iowa	63,902	508,942	12.6
Kansas	43,867	421,593	10.4
Kentucky	110,814	735,953	15.1
Louisiana	151,954	664,692	22.9
Maine	26,984	256,214	10.5
Maryland	56,812	754,638	7.5
Massachusetts	199,727	1,029,357	19.4
Michigan	406,124	1,597,119	25.4
Minnesota	284,101	758,981	37.4
Mississippi	44,772	483,403	9.3
Missouri	195,036	976,397	20.0
Montana	27,592	162,779	17.0
Nebraska	30,571	273,589	11.2
Nevada	104,043	336,581	30.9
New Hampshire	13,200	208,125	6.3
New Jersey	156,607	1,294,052	12.1
New Mexico	73,567	299,538	24.6
New York	853,387	2,909,216	29.3
North Carolina	251,738	1,424,360	17.7
North Dakota	7,633	106,969	7.1
Ohio	499,819	1,852,596	27.0
Oklahoma	84,980	585,906	14.5
Oregon	249,993	593,232	42.1
Pennsylvania	864,040	2,233,074	38.7
Puerto Rico	400,991	631,298	63.5
Rhode Island	65,108	179,044	36.4
South Carolina	110,949	734,772	15.1
South Dakota	8,973	133,420	6.7
Tennessee	233,024	1,015,771	22.9
Texas	532,242	2,853,472	18.7
Utah	85,585	269,378	31.8
Vermont	3,966	106,562	3.7
Virginia	151,942	1,094,976	13.9
Washington	225,918	919,899	24.6
West Virginia	88,027	375,303	23.5
Wisconsin	243,443	883,419	27.6
Wyoming	3,942	77,197	5.1

Mr. MCCAIN. The point of all this is, the Senator from Florida, a member of the Finance Committee, felt so strongly that Medicare Advantage was at risk he decided to carve out, and was able to get the majority on a party-line vote of the Finance Committee to carve out a special status for a group of seniors under Medicare Advantage in his State. My motion simply says, everyone whom the Senator from Oklahoma made reference to deserves that same protection. That is all this motion is about.

Mr. CORNYN. If the Senator would yield for a question, if this motion is not agreed to, which protects all Medicare Advantage beneficiaries—all 11 million of them, 532,000 in my State—and as a result of not only these cuts but perhaps additional cuts to come in the future to Medicare Advantage, which will make it harder for Medicare beneficiaries to get coverage, I ask particularly my doctor colleagues, what is the impact of eliminating Medicare Advantage and leaving people with Medicare fee-for-service, which is, as I recall, the Bennet amendment earlier? You have to parse the language closely, but it talked about guaranteed benefits. I think the Senator from Oklahoma makes a good point. Right now, Medicare Advantage has guaranteed benefits.

Mr. COBURN. Absolutely.

Mr. CORNYN. What is the consequence of seniors losing Medicare Advantage and being forced onto a Medicare fee-for-service program?

Mr. COBURN. Limited prevention screening, no coordinated care, loss of access to certain drugs, loss of accessory things, such as vision and hearing

supplementals, but, more importantly, poorer health outcomes. That is what it is going to mean—or a much smaller checkbook, one or the other. A smaller checkbook because now the government isn't going to pay for it—you are—or poorer health outcomes. If your checkbook is limited, the thing that happens is, you will get the poorer health outcome.

Mr. BARRASSO. Additionally, the Senator from Arizona talked about the closed-door meetings, secretly trying to come up with things.

There was an article in the paper today that the Democrats are turning to actually throwing more people on the Medicare and Medicaid rolls as they are trying to come up with some compromise; the idea being it is going to be compromising the care of the people. They are trying to put more people onto the Medicaid rolls. The Senator from Tennessee has said many physicians don't take those patients because reimbursement is so poor. It is putting more people into a boat that is already sinking. They want to put more people on Medicaid and more on Medicare, but at the same time they are cutting Medicare by \$464 billion. This is a program we know is already going broke. Yet they want to now put people age 55 to 64, add those to the Medicare rolls, which is a program we have great concerns about.

Special deals for some, cutting out many others, now adding more people to the Medicare rolls—to me, this is not sustainable. Yet these are the deals that are being cut less than 100 feet from here off the floor of the Senate, when we are out here debating for all the American people to see the things

we think are important about health care. Jobs are going to be lost as a result, if this bill gets passed. People who have insurance will end up paying more in premiums, if this bill is passed. People who depend on Medicare, whether it is Medicare Advantage or regular Medicare, will see their health care deteriorate as a result of this proposal. I turn to the Senator from Arizona, who has been a special student of this.

Mr. MCCAIN. So seniors, by losing Medicare Advantage, would then lose certain provisions Medicare Advantage provides and then they would be forced, if they can afford it, which they are now paying zero because it is covered under Medicare Advantage, then they would have to buy Medigap policies that would make up for those benefits they lost when they lose Medicare Advantage.

Guess who offers those Medigap insurance policies. Our friends at AARP, which average \$175 a month. We are telling people who are on Medicare Advantage today, when they lose it, they can be guaranteed, if they want to make up for those benefits they are losing, they would be paying \$175 a month, minimum, for a Medigap policy. A lot of America's seniors cannot afford that.

Mr. COBURN. That is \$2,000 a year.

Mr. MCCAIN. They can't afford it.

Mr. COBURN. I will make one other point. Over the next 10 years, 15 million baby boomers are going to go into Medicare. We are taking \$465 billion out of Medicare; on the 10-year picture, \$1 trillion. So we are going to add \$15 billion and cut \$1 trillion. What do you think is going to happen to the care for everybody in Medicare? The ultimate

is, we are going to ration the care for seniors, if this bill comes through.

Mr. MCCAIN. How much time remains, Madam President?

The PRESIDING OFFICER. Five minutes is remaining.

Mr. MCCAIN. I ask Dr. BARRASSO, have you treated people under Medicare Advantage?

Mr. BARRASSO. I have. People know there is an advantage to being in this program, and that is why they sign up for it. That is why citizens all around the country have signed up for Medicare Advantage. They realize there is value in prevention and there is value in coordinated care. There is value in having eye care, dental care, hearing care. There are advantages to wanting to stay healthy, to keep down the cost of care.

Mr. MCCAIN. So you are making the case that even though it may cost more, the fact that you have a weller and fitter group of senior citizens, you, in the long-run, reduce health care costs because they take advantage of the kind of care that, over time, would keep them from going to the hospital earlier or having to see the doctor more often.

Mr. BARRASSO. That is one of the reasons that Medicare Advantage was brought forth. I know a lot of Senators from rural States supported it because it would allow people in small communities to have this advantage to be in a program such as that. It could encourage doctors to go into those communities to try to keep those people well, work with prevention. The 11 million people who are on Medicare Advantage know they are on Medicare Advantage. They have chosen it. It is the fastest growing component because people realize the advantages of being on Medicare Advantage. If they want to stay independent, healthy, and fit, they sign up for Medicare Advantage. I would think people all across the country, who are seniors on Medicare but are not on Medicare Advantage, would want to say: Why didn't I know about this program? As seniors talk about this at senior centers—and I go to centers and meetings there and visit with folks and hear their concerns—they are converting over and joining, signing up for Medicare Advantage because they know there are advantages to it. For this Senate and the Democrats to say: We want to slash over \$100 billion from Medicare Advantage, I think the people of America understand this is a great loss to them and a peril to their own health, as they lose the coordinated care and the preventive nature of the care.

Mr. MCCAIN. I ask the Senator from Tennessee, do you know of any expert economist on health care who believes we can make these kinds of cuts in Medicare Advantage and still preserve the same benefits the enrollees have today?

Mr. ALEXANDER. The answer to the Senator from Arizona is no. I do not know of one. I know of one Senator at

least who does not believe it. He is the Senator from Florida. It is interesting that all week we have been going back and forth. We have been saying to the Democrats: You are cutting Medicare benefits. They have been saying: No, we are not.

We have been saying: Yes, you are.

No, we are not.

I am sure the people at home must say: Well, who is right about this? Well, the Senator from Florida, who sits on the other side of the aisle, has said: I am not willing to go back to Florida and say to the people of Florida that your benefits are going to be cut if you are on Medicare Advantage, so I want an amendment to protect you. The Senator from Texas wants an amendment to protect 11 million seniors and so does the Senator from Oklahoma and so does the Senator from Louisiana and so does the Senator from Wyoming, and the Senator from Tennessee.

So the Senator from Arizona is saying, we believe you are cutting Medicare Advantage benefits for 11 million Americans. The Senator from Florida does not trust your bill. We do not either. We want an amendment that protects 11 million seniors.

Mr. CORNYN. Madam President, I would ask our Senators to expand in the brief time we have. It seems as if all of the discussion about health care reform is a bit about accountable care organizations, coordinating care, particularly in the later part of life, avoiding chronic diseases in life.

When I was at Kelsey-Seybold Clinic in Houston, TX, they told me it is Medicare Advantage that allows them to coordinate care, to hold down costs, to keep people healthier longer. Yet the irony, to me, it seems, is that by cutting Medicare Advantage benefits, we are going backward rather than forward when it comes to that kind of coordinated, less expensive care.

Would the Senator concur with that?

Mr. BARRASSO. I would concur that this is actually taking a step backward. That is why the Senator from Florida has demanded they make accommodations for the people of Florida. The people of Wyoming want those same accommodations, as do the people of Arizona and Texas. Because 11 million Americans have chosen the Medicare Advantage Program because it does help coordinate care. It has preventive care. It keeps it more patient centered as opposed to government centered, insurance company centered. That is the way for people to stay healthy, live longer lives, and keep their independence.

We have seen cuts across the board on Medicare, whether it is home health, nursing homes, hospice care, Medicare Advantage. And across the board, they are cutting Medicare in a way that certainly the seniors of this country do not deserve. They have paid into that program for many years and they deserve their benefits.

Mr. ALEXANDER. If I may say to the Senator from Arizona one other

thing, we have talked a lot about our good friend, the Senator from Florida, and how he has been so perceptive on noticing that his Floridians with Medicare Advantage may lose their Medicare benefits.

The PRESIDING OFFICER. The Senator's time is expired.

Mr. MCCAIN. Madam President, I ask unanimous consent for an additional 30 seconds for the Senator.

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

Mr. ALEXANDER. I say to the Senator from Arizona, I believe there are other Medicare benefits that are likely to be cut in this bill. Aren't there cuts to hospice? Aren't there cuts to hospitals? Aren't there cuts to home health care, which we talked about yesterday? So if Floridians do not trust the Democratic bill to protect their Medicare benefits from Medicare Advantage, why should they trust the Democratic bill to protect any of their Medicare benefits?

Mr. MCCAIN. I wish to finally point out what Dr. COBURN said. Medicare Part C, which is Medicare Advantage, is part of the law, and to treat it in any way different, because those on the other side do not particularly happen to like it, I think is an abrogation of the responsibilities we have to the seniors of this country.

I thank my colleagues and yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

AMENDMENT NO. 2962

Mrs. HUTCHISON. Madam President, I rise today to talk about another amendment that is pending, the Nelson-Hatch-Casey amendment. This is an amendment that I think has been discussed in the last day as well. That is the amendment that would assure that no Federal funds are spent for abortion. That was unclear. It is unclear in the underlying bill. I think it is very important we talk about it, that we make sure it is very clear exactly what the Nelson-Hatch-Casey amendment does; and that is, it would bar Federal funding for abortion, which is basically applying the Hyde amendment to the programs under this health care bill.

Since the Hyde amendment was first passed in 1977, the Senate has had to vote on this issue many times, probably just about every year, and I have consistently voted to prohibit Federal funding for abortions, as I know my colleague and friend from Utah has done, as well as the Democratic sponsors of this amendment.

Yet it seems that some Members were on the floor last night misconstruing exactly what the Nelson-Hatch-Casey amendment does. Specifically, their claim was that the Hyde language only bars direct funding for elective abortions while the Nelson-Hatch-Casey amendment bars funding of an entire benefits package that includes elective abortions and therefore is unprecedented.

I wish to ask the distinguished Senator from Utah, what exactly did the Hyde language say? Let's clarify what Hyde was, so you can then determine if your amendment is the same.

Mr. HATCH. I thank the Senator so much.

The current Hyde language contained in the fiscal year 2009 Labor-HHS Appropriations Act says the following:

SEC. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

Mrs. HUTCHISON. So Federal funds are prohibited from being used in abortions in that particular bill.

What about programs such as CHIP, that was created in the Balanced Budget Act? And in 2009, it was reauthorized by Congress and signed by the President earlier this year. What about the CHIP program?

Mr. HATCH. I know a little bit about CHIP. That was the Hatch-Kennedy bill. I was one of the original authors of the program and insisted that the following language be included in the original statute:

#### LIMITATION ON PAYMENT FOR ABORTIONS

(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

That is what the CHIP bill said, and that was the Hatch-Kennedy bill.

Mrs. HUTCHISON. I would assume you do know what is in that bill. What about the Federal Employees Health Benefits Plan, what does it say?

Mr. HATCH. The reason I mentioned Senator Kennedy is because he was the leading liberal in the Senate at the time, and yet he agreed to that language.

As to the Federal Employees Health Benefits package, the following language appears in the Financial Services and General Government Appropriations Act for fiscal year 2009:

SEC. 613. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees' health benefits program which provides any benefits or coverage for abortions.

SEC. 614. The provisions of Section 613 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.

Mrs. HUTCHISON. Well, isn't that the same as the language in the Nelson-Hatch-Casey amendment?

Mr. HATCH. You are absolutely right.

Let me read the language for you in the Nelson-Hatch-Casey amendment.

IN GENERAL.—No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion.

Mrs. HUTCHISON. So based on what you have said, this is not new Federal abortion policy. The Hyde amendment currently applies to the plans discussed, including the plans that Members of Congress have. And the abortion protections for all of the Federal health programs all say exactly the same thing.

The amendment we are going to vote on that is the Nelson-Hatch-Casey amendment would preserve the three-decades-long precedent—that is what your amendment does—and that we must pass it if we are going to guarantee that the bill that is on the floor is properly amended so it is the same as our 30 years of abortion Federal policy in this country?

Mr. HATCH. Right. The reason it is so critical we pass the Nelson-Hatch-Casey amendment is that it is the only way to guarantee that taxpayers' dollars are not used by the insurance plans under the Democrats' bill to pay for abortions. In other words, the Hyde language is in the appropriations process. We have to do it every year rather than making it a solid amendment. But this bill is not subject to appropriations. So if we leave the Hyde language out of this bill, the language we have in the amendment, the Nelson-Hatch-Casey amendment, then we would be opening up a door for people who believe that abortion ought to be paid for by the Federal Government to do so. And we should close that door because that has been the rule since 1977.

Mrs. HUTCHISON. I thank the Senator for the explanation. I thank the Senator from Utah because I do think it is important people know. There has been a lot of questions raised about the bill and whether it would be a foot in the door for changing a policy that has been the law of our country, and accepted as such. Whether it was a Democratic-controlled Congress or a Republican-controlled Congress, I think everyone has agreed this Hyde amendment language has protected Federal taxpayers who might have a very firm conviction against abortion so they would not have to be subsidizing this procedure.

Mr. HATCH. I appreciate the Senator from Texas pointing this out. The current bill has language that looks like it is protective, but it is not. That is what we are trying to do: close the loophole in that language and get it so we live up to the Hyde amendment, which has been in law since 1977.

To be honest with you, I do not see how anybody could argue that the taxpayers ought to be called upon to foot the bill for abortions. Let's be brutally frank about it. The taxpayers should not be called upon to pay for abortions. The polls range from 61 percent of the American people, including many pro-

choice people, who do not believe taxpayers should pay for abortions, to 68 percent. The polls are from 61 to 68 percent of those who do not believe the taxpayers ought to be paying for abortion, except to save the life of the mother or because of rape or incest. And we have provided for those approaches in this amendment. So anybody who argues otherwise is plain not being accurate.

Mr. SPECTER. Madam President, will the Senator from Utah be willing to yield for a question?

Mr. HATCH. Sure.

Mr. SPECTER. My question relates to the provisions of the pending bill, section 1303(2)(A), which specifies that the plan will not allow for any payments of abortion, and where there is, as provided under section 1303(2)(B), there will be a segregation of funds. So that under the existing statute, there is no Federal funding used for abortion. But a woman has the right to pay for her own abortion coverage. And with the status of Medicaid, where the prohibition applies to any Federal funds being used to pay for an abortion, there are 23 States which allow for payment for abortion coverage coming out of State funds.

So aren't the provisions of this statute, which enable a woman to pay for an abortion on her own, exactly the same as what is now covered under Medicaid, without violating the provisions of the Hyde amendment?

Mr. HATCH. Well, the way we view the current language in the bill is that there is a loophole there whereby they can even use Federal funds to provide for abortion under this segregation language, and that is what we are concerned about. We want to close that loophole and make sure that the Federal funds are not used for abortion.

Like I say, there are millions of people who are pro-choice who agree with the Hyde language. All we are doing is putting the Hyde language into this bill in a way that we think will work better.

Mr. SPECTER. If the Senator will yield further.

Mr. BROWNBACK. Will the Senator yield for a comment?

Mr. HATCH. I would be happy to yield.

Mr. BROWNBACK. In responding to the Senator from Pennsylvania as well, I wish to quote BART STUPAK, who carried the same sort of amendment you are putting forward, only on the House side. The same sorts of questions, naturally, were coming forward, saying: OK, you are blocking abortion funding for the individual. He said this—and I am quoting directly from Representative STUPAK:

The Capps amendment—Which is in the base Reid bill here—departed from Hyde in several important and troubling ways: by mandating that at least one plan in the health insurance exchange provide abortion coverage, by requiring a minimum \$1 monthly charge for all covered individuals that would go toward paying for abortions and by allowing individuals receiving Federal affordability credits—

Those are Federal dollars—  
to purchase health insurance plans that  
cover abortion. . . .

In all those ways, the Capps amend-  
ment—which is in the Reid bill—ex-  
pands and does allow Federal funding  
of abortion that we have not done for  
33 years.

Going on with Representative STU-  
PAK's statement:

Hyde currently prohibits direct federal  
funding of abortion. . . . The Stupak amend-  
ment—

Which is also the Nelson-Hatch  
amendment—

is a continuation of this policy—

Of the Hyde amendment—

nothing more, nothing less.

I think it is important to clarify that  
this is a continuation of what we have  
been doing for 33 years that the Sen-  
ator from Utah and the Senator from  
Nebraska are putting forward with this  
amendment.

I thank my colleague for yielding.

Mr. HATCH. Madam President, I  
thank my colleague for bringing it for-  
ward. The segregation language is very  
problematic language. That is what we  
are trying to resolve. We basically have  
all agreed with the Hyde amendment,  
which is from 1977, and this would, in  
effect, incorporate the language in the  
bill.

Mr. JOHANNIS. Would the Senator  
yield for another comment?

Mr. HATCH. Sure.

Mr. JOHANNIS. I might just offer a  
thought here on that language. The Na-  
tional Right to Life group saw through  
that gimmick immediately. It took  
them about 20 seconds to figure out  
what was happening here. I think they  
referred to it as a "bookkeeping gim-  
mick," that somehow there would be  
some segregation if the Federal money  
went in your left pocket but you paid  
for abortions out of your right pocket.  
It doesn't make any sense. That seg-  
regation isn't going to work. They saw  
through it. They saw the gimmick it  
was.

Let me just say, I support the Sen-  
ator's amendment. I applaud Senator  
HATCH and Senator NELSON and Sen-  
ator CASEY for bringing this very im-  
portant issue forward. I applaud you  
for keeping this effort that started  
with the Hyde amendment—or Hyde  
language, rather—because what we are  
really doing here is we are saying very  
clearly to the American people, wheth-  
er directly or indirectly, your tax dol-  
lars are not going to be used to buy  
abortions.

Thank you for your leadership on  
this issue. I am happy to be here to  
support that.

Mr. SPECTER. Would the Senator  
from Utah respond to my question?  
How can you disagree with the provi-  
sions of section 1303(2)(A) of the bill  
which is pending which specifies that if  
a qualified health plan provides serv-  
ices for abortion—this is the essence of  
it—if a qualified health plan provides  
coverage for services for abortion, the

issuer of the plan should not use any  
amount of the Federal funds for abor-  
tion? So there is a flatout prohibition  
for use of Federal funds. And under sec-  
tion 1303(2)(B), there is a segregation of  
funds which is identical to Medicaid.

So however you may want to charac-  
terize it, how do you respond to the  
flat language of the statute which ac-  
complishes the purpose of the Hyde  
amendment and allows for a payment  
by collateral funds, just as Medicaid  
pays for abortions without Federal  
funds?

Mr. HATCH. Let me respond to the  
distinguished Senator, although I am  
not going to ask him a formal ques-  
tion. If that is true, then why have the  
Capps language in there? Why don't we  
just take the Hyde language, which is  
what we are trying to do. It isn't true.  
We know in this bill there will be sub-  
sidization to help people pay for health  
insurance. In fact, the subsidization  
can go to people up to \$88,000 a year,  
and that could be indirectly used for  
abortion. It is a loophole that Hyde  
closes.

If the distinguished Senator from  
Pennsylvania believes the Capps lan-  
guage does what Hyde meant to begin  
with and what it has been since 1977,  
what is wrong with putting the Hyde  
language in here and solving the prob-  
lem once and for all? We see it as a  
loophole through which they can actu-  
ally get help from the Federal Govern-  
ment directly and indirectly to pay for  
abortion.

Now, let's think about it. There are  
no mandates in this language that we  
have for elective abortion coverage.  
Plans and providers are free from any  
government mandate for abortion.  
There is no Federal funding of elective  
abortion or plans that include elective  
abortion except in the cases where the  
life of the mother is in danger or the  
pregnancy is caused by rape or incest.  
The amendment allows individuals to  
purchase a supplemental policy from a  
plan that covers elective abortion as  
long as it is purchased with private  
dollars. The amendment prohibits the  
public plan from covering elective  
abortions. It prevents the Federal Gov-  
ernment from mandating abortion cov-  
erage by private health plans or pro-  
viders within such plans. And insur-  
ance plans are not prevented from sell-  
ing truly private abortion coverage,  
even through the exchange. This  
amendment doesn't prohibit that.

The bottom line: The effect on abor-  
tion funding and mandates is exactly  
the same as that of the House bill  
changed by the Stupak amendment.

Now, look, if the distinguished Sen-  
ator from Pennsylvania believes the  
Capps language is the same as Hyde, he  
is wrong. And if he believes it does  
what Hyde would do, he is wrong there.  
Why not just put the Hyde language in  
once and for all, which has been there  
since 1977? That is what the Stupak  
language is.

The Hyde amendment specifically re-  
moves abortion from government pro-

grams, but the Reid bill specifically al-  
lows abortion to be offered in two huge  
new government programs. The Reid  
bill tries to explain this contradiction  
by calling for the segregation of Fed-  
eral dollars when Federal subsidies are  
used to purchase health plans. This  
"segregation" of funds actually vio-  
lates the Hyde amendment which pre-  
vents funding of abortion not only by  
Federal funds but also by State match-  
ing funds within the same plan. Simply  
put, today, Federal and State Medicaid  
dollars are not segregated. So that is  
the difference.

If the distinguished Senator from  
Pennsylvania believes the current lan-  
guage in the Reid bill meets the quali-  
ties of the Hyde language, then why  
not just put the Hyde language in once  
and for all since it has been in law  
since 1977?

It is important to note that today  
there is no segregation of Federal funds  
in any Federal health care program.  
For example, the Medicaid Program re-  
ceives both Federal and State dollars.  
There is no segregation of either the  
Federal Medicaid dollars or the State  
Medicaid dollars.

With that, I know I have some col-  
leagues who have asked for some time  
to speak, so I will yield the floor.

Mr. VITTER addressed the Chair.

Mr. SPECTER. The Senator from  
Utah has not yet answered the ques-  
tion.

The PRESIDING OFFICER. The Sen-  
ator from Louisiana is recognized.

Mr. VITTER. Thank you, Madam  
President.

I strongly support the efforts of the  
distinguished Senator from Utah and  
his amendment offered along with Sen-  
ator NELSON and Senator CASEY. And I  
think this exchange and this colloquy  
is very helpful. In fact, I think it  
proves the point, particularly the par-  
ticipation of the Senator from Pennsyl-  
vania in it. The only folks who are de-  
fending the language in the Reid bill  
are folks who are clearly and strongly  
pro-choice, pro-abortion. Folks who  
have a fundamental problem with that  
all say the underlying language in the  
Reid bill has huge loopholes. That in-  
cludes people who want to support the  
bill otherwise. I am strongly against  
this bill. I am not in that category.  
But, as the distinguished Senator, Mr.  
BROWNBACK, mentioned, Representative  
STUPAK wants to support the under-  
lying bill. He supported it in the House,  
but he was very clear in his efforts on  
the House floor that the underlying  
language, which is now in the Reid bill,  
had huge loopholes, wasn't good  
enough, needed to be fixed. That is why  
he came up with the Stupak language,  
and that is essentially exactly what we  
have in this amendment.

Similarly, the U.S. Conference of  
Bishops is very supportive of the con-  
cepts of the underlying bill, but they  
have said clearly that the Reid bill is  
"completely unacceptable" on this  
abortion issue and "is actually the  
worst bill we have seen so far on the  
life issues."

So this colloquy involving the distinguished Senator from Pennsylvania, I think that general debate proves the point clearly.

I again compliment the Senator from Utah, along with Senator NELSON, Senator CASEY, and others—I am a cosponsor of the amendment—on this effort. We need to pass this on the bill. This will do away with the loophole. This will be real language to truly prohibit taxpayer funding of abortions. This constitutes exactly the same as that long tradition, since 1977, of the Hyde amendment. This marries the Stupak language, so it should be crystal-clear.

What will this amendment specifically do? It will mean there are no mandates for elective abortion coverage. Plans and providers are free from any government mandate for abortion under this amendment language. It would mean there is no Federal funding of elective abortion or plans that include elective abortion except in the case of when the life of the mother is in danger or in case of rape or incest. It means this amendment would allow individuals to purchase a supplemental policy or a plan that covers elective abortion as long as that separate policy is purchased completely with private dollars. It would prohibit the public plan from covering those elective abortions and prevent the Federal Government from mandating abortion coverage by any private plan. Insurance plans are not prevented from selling truly private abortion coverage, including through the exchange, but taxpayer dollars would have nothing—absolutely nothing—to do with it.

Bottom line: The effect on abortion funding and mandates is exactly the same as the long and distinguished tradition of the Hyde amendment with this amendment, and it would be exactly the same as the Stupak language on the House side.

I also agreed with the distinguished Senator from Utah when he said this should not be of any great controversy. Abortion is a deeply divisive issue in this country, but taxpayer dollars being used to pay for abortion is not. There is a broad and a wide and a deep consensus against using any taxpayer dollars to pay for abortion. The Senator from Utah mentioned polls. That is why the Hyde amendment has been longstanding since 1977. That is why it has been voted for and supported and passed again and again in Congresses with Democratic majorities and Republican majorities. It is a solid consensus. It does represent the common sense of the American people. Certainly, I will follow in a similar, proud tradition of Louisiana Senators supporting that consensus. Every U.S. Senator from Louisiana since the Hyde amendment was originally adopted has strongly supported this commonsense consensus view—every Senator. Everyone but me has been Democratic, but every sitting U.S. Senator from Louisiana has supported that commonsense consensus

view, and I surely hope that tradition continues today.

Again, I applaud the Senator from Utah and his leading cosponsors, Senator NELSON and Senator CASEY, on this effort, and I encourage all of my colleagues, Democrats and Republicans, to come together around what the American people consider a real no-brainer, a true consensus, something that clearly reflects the common sense of the American people. Is abortion a divisive issue? Yes. Is using taxpayer dollars to fund abortion a close question? No. There is a clear consensus in America not to use any taxpayer dollars to fund abortion. It is crystal-clear that we need to pass this amendment, and the underlying language in the Reid bill is completely unacceptable.

With that, thank you, Madam President. I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I am very appreciative of the Senator from Texas, the distinguished Senator from Louisiana, the distinguished Senator from Nebraska, and, of course, the distinguished Senator from Kansas and the distinguished Senator from South Dakota who are here on the floor and participating. I believe we have until 12:27, so I am going to relinquish the floor.

Mr. THUNE. Before the Senator leaves, I wish to put one fine point on something the Senator said in response to the question from the Senator from Pennsylvania about the use of Medicaid funds in the States.

There are a number of States that do provide programs that have abortion funding, but I think there is a very clear distinction that needs to be made in Medicaid funds which are matching funds, and none of those funds can be used to fund abortions. You said that in response to his question, but I think that point needs to be made very clearly because the Senator from Pennsylvania was implying that somehow, since States have created programs to fund abortions and since Medicaid is a Federal and State program, that somehow those two are being mixed, and that this idea that because they are calling for “segregation,” that really doesn’t exist in the Medicaid Program.

The Medicaid Program—those are matching funds—is a Federal-State program. The Federal dollars that go into the Medicaid Program—the prohibition that exists on Federal funding of abortions applies to Medicaid dollars that go to the States, to the degree that States have adopted programs that fund abortion. Those are State funds and not Medicaid funds, which are matching funds.

Mr. HATCH. I am glad the Senator made that even more clear. Last night, a number of Democrats completely distorted this issue. If they think the Capps language equals the Hyde language, why not put it in? They want to be able to fund abortion any way they

possibly can, to fund it in a variety of ways, with Federal dollars, if we don’t put the Hyde language in. That is what this is about.

Mr. BROWNBACK. Will my colleague yield?

Mr. HATCH. I am happy to.

Mr. BROWNBACK. If you are not clear about this, then abortion will be funded. If there is any of this that needs clarity one thing is for certain with the Capps language in the baseline of the Reid bill, that abortion will be funded.

The Commonwealth of Massachusetts recently passed its State-mandated insurance, Commonwealth Care, without an explicit exclusion on abortion. Guess what. Abortions there were also funded immediately. In fact, according to the Commonwealth Care Web site, abortion is considered covered as outpatient medical care. That is a point about being clear with the Hyde-type language, which is the Nelson-Hatch language, which says: No, we are not going to fund this, and we are going to continue the 33-year policy. If we keep the Capps language in that funds abortion—the last time the Federal Government funded abortions was during that 3-year period after Roe, but before Hyde, and we were funding about 300,000 abortions a year. The Federal taxpayer dollars funded abortions through Medicaid.

I cannot believe any of my colleagues would say: Yes, I would be willing to buy into that 300,000 abortions a year when President Obama and President Clinton said we want to make abortions safe, legal, and rare. Well, 300,000 a year would not be in that ballpark. That is the past number that happened when you didn’t have Hyde language in place at the Federal level.

Mr. HATCH. That is what it will do here too. All this yelling and screaming when they say it equals the Hyde language—it doesn’t. That is the problem. If they want to solve the problem, why not use the Hyde language that has been accepted by every Congress since 1977? The Senator is right that there were 300,000 abortions a year between 1973 and 1977 because we didn’t have the Hyde language. We got tired of the taxpayers paying for them. Why should they pay for it? Why should taxpayers who are pro-life—for religious reasons or otherwise—have to pay for abortions, elective abortions by those who are not? They should not have to.

To be honest, the language in the current bill is ambiguous and it would allow that. Anybody who is arguing this is the same as the Hyde language hasn’t read the Capps language. We want to change it to go along with Hyde. It doesn’t affect the right to abortion, except that we are not going to have taxpayers paying for it.

Mr. THUNE. If the Senator will yield—

Mr. HATCH. Yes.

Mr. THUNE. That is what STUPAK and other Members of the House of Representatives saw; that this created

tremendous ambiguity and they sought to tighten it up and reinstate the long-standing policy regarding Federal funds and their use to finance abortions since 1977, the Hyde language. The Stupak amendment to the House bill passed with 240 votes. There was a sizable, decisive majority of Members in the House of Representatives who saw through what the ambiguity was that exists regarding the House bill and now the Senate bill.

This is intentionally ambiguous for the reasons you mentioned. This simply clarifies, once and for all, what has been standard policy at the Federal level going back to 1977. As the Senator stated earlier, I believe it represents the consensus view in America of both Republicans and Democrats who believe this is ground we can all stand on, irrespective of where people come down on this issue; that the idea that somehow Federal taxpayer funds ought to finance abortions is something most Americans disagree with. That is why there has been such broad, bipartisan support for this particular policy, and that is why it should be extended into the future.

As the Senator from Utah said, 61 percent are against funding abortions. But I have seen polls that suggest it is much higher than that. I know it is much higher in my State of South Dakota. I commend the Senator for seeing his way to offer an amendment that clarifies and removes all this ambiguity and what, to me, is clearly an intentional ambiguity regarding this issue and the underlying bill.

Mr. HATCH. Madam President, I ask unanimous consent that Senator CORNYN be added as a cosponsor to the Nelson-Hatch-Casey amendment.

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

The Senator from Nebraska is recognized.

Mr. JOHANNIS. Madam President, how much time remains?

The PRESIDING OFFICER. There is 4 minutes remaining.

Mr. JOHANNIS. Madam President, I have been on the floor a number of times debating this issue, a while back on a motion to proceed and since this amendment has come up. I wish to tell the Senator from Utah that I don't believe I have seen a more concise, clear explanation of the history of the Hyde language than I saw over the last half hour of debate on the Senate floor. The Senator laid it out perfectly. The Senator laid out how we have, over a long period of time, stayed with that Hyde language. That was the agreement that had been reached.

Our colleague from Texas said this is a foot in the door, and I agree with her. If this Reid bill passes with the current language on abortion, it is not only a foot in the door but, in my estimation, it kicks down the door. It kicks down the door and sets up structure for the Federal funding of abortions. That is what we are going to end up with.

A couple weeks ago, I came to the floor when we were debating the mo-

tion to proceed and I said, at that time, to me, this is the pro-life vote, because if this bill goes to the floor, we will now need 60 votes to get an amendment passed. I said I don't count the 60. I issued a challenge and I said: If there is any Member who has a list of 60 Members who will vote for this amendment, I am willing to look at that and change my view of the world. Well, that hasn't happened.

In fact, there are many predictions being made that, sadly and unfortunately, this amendment will not get the 60 votes it needs.

Let me put this into context. For pro-life Senators, this is the vote, but it doesn't stop here. In my estimation, you are pro-life on every vote. You don't get a pass on this vote or that vote or the next vote or whatever the vote is. You are pro-life all the way through.

Even if this amendment doesn't pass, I wish to make the case that this bill should not go forward because it literally will create a system, a structure, a way to finance abortions. I don't believe that is what this country wants. Many Senators, including the Senator from South Dakota and the Senator from Kansas, have very clearly made the case that the people of the United States do not want their tax dollars to go to buying abortions.

My hope is, 60 Senators will step up on this amendment. I will sure support it. I will speak everywhere I can in support of it. I am so appreciative that Senator NELSON and Senator HATCH and Senator CASEY brought this forward. I am glad to be a cosponsor. It is my hope this amendment will pass.

It is my conviction that we need to stand strong throughout this debate and make sure this language doesn't end up in the final bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Madam President, I think the Catholic bishops have put it as concisely as anybody:

In every major Federal program where Federal funds combine with nonfederal funds (e.g. state or private) to support or purchase health coverage, Congress has consistently sought to ensure that the entire package of benefits excludes elective abortion. For example, the Hyde amendment governing Medicaid prevents the funding of such abortions not only using federal funds themselves, but also using the state matching funds that combine with the federal funds to subsidize the coverage. A similar amendment excludes elective abortions from all plans offered under the Federal Employees Health Benefits Program, where private premiums are supplemented by a federal subsidy. Where relevant, such provisions also specify that federal funds may not be used to help pay for administrative expenses of a benefits package that included abortions. Under this policy, those wishing to use state or private funds to purchase abortion coverage must do so completely separately from the plan that is purchased in whole or in part with federal financial assistance. This is the policy that health care reform legislation must follow if it is to comply with the legal status quo on federal funding of abortion coverage. All of

the five health care reform bills approved by committee in the 111th Congress violate this policy.

Following the Hyde amendment principles is what we have done for 33 years, until this moment, until the Capps language in the Reid bill. Now we have flipped that on its head and are saying you can combine Federal funds with non-Federal funds to pay for elective abortions. That was the policy prior to Hyde in 1977. That funded 300,000 abortions, roughly, a year at that point in time. There is no way in this country that is a policy the American people support. They don't. They may be divided about abortion but not about Federal funding for elective abortion. There is no division about that at all. It has been very consistent policy, until we have seen the Reid bill, this particular piece of legislation. We have been quite consistent about this. It is my hope my colleagues will say: I may be pro-choice, but I have consistently supported Hyde because I think we should not be funding elective abortions.

I hope they will vote for the Nelson-Hatch amendment because of that very feature. It is not about abortion, it is about the funding of elective abortions. I hope we don't go in that direction.

I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired. The Senator from Montana has 3 minutes 17 seconds.

Mr. BAUCUS. Madam President, with respect to the last debate, let's be clear that the underlying bill keeps the three-decades-old agreement that has implemented the Hyde amendment to separate Federal funds from private funds when it comes to reproductive health care.

The Nelson-Hatch amendment is unnecessary. It is discriminatory against women. Women are the only group of people who are told how to use their own private money. That is unfair.

On another matter, with respect to the McCain motion, let me explain a little bit about Medicare Advantage and how it works. Essentially, the Medicare Advantage Programs are insurance companies. They are insurance companies that have their own officers, directors, their own marketing plans and their own administrative costs and they are concerned about the rate of return on investment for their stockholders. These are simple, garden variety, ordinary insurance companies.

In this case, they are insurance companies that get general revenue from payroll taxes and premiums. They are basically insurance companies that give benefits to senior citizens. These insurance companies are overpaid. There is not much disagreement that they are overpaid. How are they paid? Well, believe it or not, these insurance companies—Medicare Advantage plans—are paid according to the amount Congress sets in statute. That is their payment rate, what Congress sets in statute.

The problem is, by doing so, these preset rates overstate the actual cost of providing care by 30 percent. We pay more than it costs to provide care by about 30 percent, in many cases. These overpayments also clearly promote inefficiencies in Medicare. Also, these payments have not been proven to increase the quality of care seniors receive. In the estimate I saw, about half the Medicare Advantage plans have care coordination and half don't. Half are no better than ordinary fee-for-service plans. Because of this broken, irrational payment system, some plans receive more than \$200 per enrollee per month and others receive about \$36 per enrollee per month.

Again, the payment rates are set by statute, relating to fee for service in the area. It is broken. It doesn't make sense. It causes great dislocations and differences in the payment rates. Frankly, under this broken system, all beneficiaries are not receiving the same care. I believe all beneficiaries should be able to have access to the best care, not just those who happen to live in States with high payment rates.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BAUCUS. Madam President, I ask unanimous consent to continue for an additional 5 minutes.

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

Mr. BAUCUS. Madam President, I have said these Medicare Advantage plans are overpaid. Nobody disagrees with that. They are overpaid. The Senator from Oklahoma, Mr. COBURN, when I asked him a few days ago if he thought they were overpaid, said: Yes, they are overpaid. The MedPAC advisory board tells us: Yes, they are overpaid.

Here is a statement made by Tom Scully, former Administrator of the Center for Medicare and Medicaid Services:

I think Congress should take some of it away. There's been huge over-funding.

There are lots of other citations from Wall Street analysts and others in the industry saying clearly the Medicare Advantage plans are overpaid. Frankly, we, in Congress, put a statutory provision in law that has caused this overpayment. Clearly, we should fix it.

In addition, something that is pretty alarming is, according to a study I saw, only about 14 cents on the dollar of extra payments to Medicare Advantage plans goes to beneficiaries—only 14 cents—which means 86 cents on the dollar goes to the company, not to the beneficiaries, not to the enrollees but to the companies—"the companies" meaning the officers, directors, administrative costs, marketing costs, rate of return. It is to the company, any ordinary, garden variety company. Therefore, it behooves us to find a better way to pay Medicare Advantage companies so it is efficient, there is not waste, and payments go primarily to enrollees, to beneficiaries.

How do we do that? This legislation moves away from the current archaic

system which sets statutory amounts in effect. Rather, we say, OK, why not have these companies bid? Let them compete based on costs in their regions. One region of the country is different from another region of the country. We are going to say what is fair here to get rid of a lot of waste and overpayments is provide that Medicare Advantage plans can compete in their area based on cost.

The plan will be paid the average bids that are based on competition in the area. We, the authors of this bill, think that is a far better way of paying for Medicare Advantage.

Will that reduce payments to beneficiaries? Certainly no. All guaranteed benefits are guaranteed in this legislation. In fact, I am going to check up on another statistic. I heard somewhere under this legislation there will be an increase of enrollees—not a decrease, an increase of enrollees. I am going to track that down because I want to be sure I am accurate.

I will conclude. I want to talk more about this issue later. There may be a separate amendment on this subject offered on our side. By and large, it is wrong to continue a current system that dramatically overpays and where 86 percent of the overpayment goes to the company and only 14 cents goes to the beneficiaries. We have to come up with a fair way of paying Medicare Advantage. I think a fair way is to have the companies competitively bid based on cost in their areas. That way they are going to get reimbursed at a level that is relevant to their area, and it is also relative to the cost they incur when they run their plans. I will have more to say about that later.

I yield the floor.

#### RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:34 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. FRANKEN).

#### SERVICE MEMBERS HOME OWNER-SHIP TAX ACT OF 2009—Resumed

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. BOXER. Mr. President, I ask unanimous consent that the time between 2:15 p.m. and 4:15 p.m. be equally divided between the two leaders, or their designees, in alternating 30-minute blocks of time, with the majority controlling the first 30 minutes and the Republicans controlling the second 30 minutes; further, that no amendments be in order during this time.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mrs. BOXER. Mr. President, since this is the 30 minutes of time for our side, I ask that I be recognized for 10 minutes, Senator MURRAY for 5 min-

utes, Senator LAUTENBERG for 5 minutes, Senator HARKIN for 5 minutes, and Senator CARDIN for 5 minutes.

We have many Members who wish to come and speak, and I would urge them to contact us. I will just take a minute to get my notes in order, so I suggest the absence of a quorum, and the time should be taken off our time.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mrs. BOXER. Mr. President, we are in the middle of a very important debate about whether we are going to move forward and make sure our people in America have health care. That is what it is about. I am going to throw out a few numbers that are always on my mind as I talk about this issue. One of them is 14,000. Every day, 14,000 Americans lose their health insurance. It is not because they did anything wrong. A lot of times it is just because they get sick and their insurance company walks away from them or they may reach the limit of their coverage, which they didn't realize they had, and they are done for. They could lose their job and suddenly they can't afford to pay the full brunt of their premium. They could get sick and then all of a sudden are now branded with a PC—and that is not a personal computer, it is a preexisting condition—and they can't get health care.

So we are in trouble in this country, with 14,000 Americans a day losing their health care, and a lot of them are working Americans. As a matter of fact, most of them are working Americans. Sometimes a child, for example, will reach the age where they can no longer be covered through their parents' plan, and the child might have had asthma. When they go to the doctor, they beg the doctor not to say they have asthma. I have doctors writing to me saying that parents are begging them: Please, don't write down that my child has asthma; say she has bronchitis because when she goes off my medical plan, she is going to be branded with a preexisting condition. So 14,000 Americans a day, remember that number.

Then, Mr. President, 66 percent, that is the percentage—66 percent—of all bankruptcies that are due to a health care crisis. People are going bankrupt not because they didn't manage their money well or they didn't work hard and save but because they are hit with a health care crisis and either they had no insurance or the insurance refused them. The stories that come across my desk, as I am sure yours, are very heartbreaking. So people are going bankrupt. They lose their dignity, they lose everything because of a health care crisis.

Yesterday, I brought up a couple of numbers—29 out of 30 industrialized nations. That is where we stand on infant mortality. We are not doing very well. It is no wonder; more than 50 percent of the women in this Nation are not seeking health care when they should. They are putting it off or they are never getting it. No wonder we don't do well with infant mortality.

Now, why don't women do this? Because they either don't have insurance or they do not have good enough insurance or they can't afford the copay or they are fearful. They are fearful that maybe if they go this time, the insurance company will say: No more.

We rank 24 out of 30 industrialized nations for life expectancy. My constituents are shocked to hear that. They are shocked at the infant mortality ranking, and they are shocked at the life expectancy ranking. I have heard my Republican friends try to rationalize this: Well, it is because our population is diverse—and all the rest. This is the most powerful, richest Nation on Earth. There is no reason we have to be 24 out of 30 in terms of our life expectancy, especially when we know so much of our problem deals with about five diseases—diseases such as diabetes, which can be prevented and certainly treated.

The last number I will talk about is 45 percent. The average family in America, by 2016, if we do nothing, will be paying 45 percent of their income on premiums. Now, this is disastrous, and 2016 is around the corner by my calculations. So that means more and more of us will not be able to afford insurance, and we are going to show up at hospital emergency rooms. That costs a lot and the outcomes are bad and America will continue on this downward spiral in relation to our health care system.

Why do I take time to talk about this issue? It is because we need to keep our eye on the big picture, and the big picture is not a pretty picture for our people right now. The status quo is not benign, it is not neutral, it is cruel. Every one of us could wake up in the morning having lost a job and having no health care. So what we are doing is going to help every American, and I think one of the best things we do in the underlying bill is to make sure that health care premiums are affordable for everyone. That is the key, and we do it in a number of ways.

But, Mr. President, in the middle of all this, we have an amendment that would roll back the clock on women's rights. I am here to say, as I said last night—and I am happy to see other colleagues joining me—it is unacceptable to single out one group of people—namely the women of this country—and tell them they can't use their own private money to buy an insurance policy that covers the range of reproductive health care. Why are women being singled out? It is so unfair.

We have had a firewall in place for 30 years. It said this: No Federal funds

can be used for abortion, but private funds can be used as long as abortion is legal, and it is. *Roe v. Wade* made it legal in the early stages of a pregnancy. Women have had that right.

Well, this amendment says there is one group of people we are going to treat differently. We are going to take one procedure, that only applies to them, and say they can't buy health insurance for that procedure—only if it is a separate rider, which everyone knows is unaffordable, impractical, and will not work.

I don't see any amendment saying to men that if they want to have a procedure that relates to their reproductive health they can't use their own private money to buy coverage for it. No, it is not in there. We don't tell men, if they want to make sure they can buy insurance coverage through their pharmaceutical plan for *Viagra*, that they can't do it. No, we don't do that, and I wouldn't support that. It would be wrong. Well, it is wrong to single out women and to say to the women of this country that they can't use their own private funds to purchase insurance that covers the whole range of reproductive health care.

You have to look behind this amendment to understand how pernicious it really is. I have five male colleagues on the other side of the aisle who were on the Senate floor for at least an hour or so talking about this amendment, and one thing about each and every one of them, they want to make abortion illegal. There is no question about it. They want to take away a woman's right to choose, even in the earliest stages of the pregnancy, even if it impacts her health, her ability to remain fertile, or her ability to avoid a very serious health issue such as a heart problem, a stroke. They do not want to have an exception for a woman's health. No question, that is what they want.

The PRESIDING OFFICER. The Senator's 10 minutes has expired.

Mrs. BOXER. I ask unanimous consent for an additional 30 seconds, and then I will turn to Senator LAUTENBERG.

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

Mrs. BOXER. So to sum up my part, the amendment that has been offered by Senators NELSON, HATCH, VITTER, BROWNBACK, et al., hurts women. It singles out one legal procedure and says: You know what. You can't use your own private funds to buy insurance so that in case you need to use it for that legal procedure, you can. So I hope we will vote it down.

I yield the floor, Mr. President, and note that Senator LAUTENBERG is here for 5 minutes. Oh, I am sorry. May I say that the order was Senator MURRAY for 5 minutes to be followed by Senator LAUTENBERG for 5.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I thank the Senator from California for her debate, for outlining the serious

concerns we have, and I rise today not only in strong opposition to the Nelson amendment but in strong support of women's health care choices, which this amendment would eliminate.

Mr. President, we can't allow a bill that does so much for women and for families and for our businesses and for the future strength of this Nation to get bogged down in ideological politics because in every single sense of the word, health insurance reform is about choices—giving options to those who don't have them: options for better care or better quality, and insurance that is within reach. This bill was never supposed to be about taking away choices, and we cannot allow it to become that.

Mr. President, this bill already does so much for millions of women across America. Already so far, the Senate has passed Senator MIKULSKI's amendment to be sure that all women have access to quality preventive health care services, and that screenings, which are so critical to keeping women healthy, are available. This underlying bill will also help women by ending discrimination based on gender-rating or gender-biased preexisting conditions, on covering maternity care, preventive care and screenings, including mammograms and well-baby care, expanding access to coverage even if an employer doesn't cover it, and giving freedom to those who are forced to stay in abusive relationships because if they leave, they or their children could lose their coverage.

Mr. President, the amendment before us today would undermine those efforts and goes against the spirit and the goal of this underlying bill. All Americans should be allowed to choose a plan that allows for coverage of any legal health care service, no matter their income, and that, by the way, includes women. But if this amendment were to pass, it would be the first time that Federal law would restrict what individual private dollars can pay for in the private health insurance marketplace.

Let me repeat that: If this amendment were to pass, it would be the first time that Federal law would restrict what individual private dollars can pay for in the private health insurance marketplace.

Now, the opponents of this bill have taken to the floor day in and day out for months arguing that this bill takes away choice. This bill doesn't take away choice, Mr. President, but this amendment sure does. This amendment stipulates that any health plan receiving any funds under this legislation cannot cover abortion care, even if such coverage is paid for using the private premiums that health plans receive directly from individuals.

Simply put, the amendment says if a health plan wants to offer coverage to individuals who receive affordability credits—no matter how small—that coverage cannot include abortion.

In this way, the amendment doesn't only restrict Federal funds, it restricts

private funds. It doesn't just affect those receiving some amount of affordability credits, it also impacts people who are paying the entire cost of coverage but who just happen to purchase the same health plan as those with affordability credits.

The bottom line: This amendment would be taking away options and choices for American women.

There is no question this amendment goes much further than current law, no matter what our colleagues on the other side contend. Current law restricts public funds from paying for abortion except in cases of rape or incest or where the woman's life is in danger. The existing bill before us represents a genuine compromise. It prohibits Federal funding of abortion, other than the exceptions I just mentioned, but it also allows women to pay for coverage with their own private funds. It maintains current law; it doesn't roll it back.

This amendment now before us would be an unprecedented restriction on women's health choices and coverage. Health insurance reform should be a giant step forward for the health and economic stability of all Americans. This amendment would be a giant step backward for women's health and women's rights. Women already pay higher costs for health care. We should not be forced into limited choices as well.

We are standing on the floor today having a debate about a broken health insurance system. It is broken for women who are denied coverage or charged more for preexisting conditions such as pregnancy or C-sections or domestic violence. It is broken when insurance companies charge women of childbearing age more than men but don't cover maternity care or only offer it for hefty additional premiums.

The status quo is not working. Women and their families need health insurance reform that gives them options, doesn't take them away.

I urge my colleagues to stand up for real reform. Reject this shortsighted amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I ask unanimous consent to amend the previous order to give Senator LAUTENBERG 8 minutes, myself 2 minutes, and Senator CARDIN 5 minutes.

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

The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, throughout my service in the Senate, I have been a strong supporter for health care reform. But we can't allow reform to be used as an excuse to roll back women's rights that they have had for almost half a century. That is why I strongly oppose the amendment offered by my friend, the Senator from Nebraska. I think he is wrong.

What this amendment does is remove a woman's right to make her own decision, as a practical matter. It is to pro-

hibit any of the health plans on the exchange from covering abortion. It will ban coverage even for women who don't get a dime in Federal subsidy.

Women's reproductive rights are always being challenged here in Congress. What about men's reproductive rights? Let's turn the tables for a moment. What if we were to vote on a Viagra amendment restricting coverage for male reproductive services? The same rules would apply for Viagra as being proposed for abortion. Of course, that means no health plan on the exchange would cover Viagra availability. How popular would that demand be around here? I understand that abortion and drugs such as Viagra present different issues, but there is a fundamental principle that is the same: restricting access to reproductive health services for one gender. This amendment is exclusively directed at a woman's right to decide for herself. It doesn't dare to challenge men's personal decisions.

I have the good fortune of being a father of three daughters and grandfather of six granddaughters. I am deeply concerned by the precedent this amendment would set. I don't want politicians making decisions for my daughters or my granddaughters when it comes to their health and well-being, but that is exactly what this amendment does.

Nothing made me happier than when any of my daughters announced a pregnancy. I watched them grow and prosper in their health and well-being, as they were carrying that child. I was fully prepared to support a decision she might make for the best health of that new baby and protecting her health to be able to offer her love and care for a new child, as I saw in my years.

I don't want to stand here and think that somebody is going to make a decision in this room that affects what my granddaughters or my daughters have to think about. If they want to restrict themselves, let them do it. But how can we stand here and permit this to take place when we are trying to make people healthier and better informed? This amendment wants to take away that right.

Right now, the majority of private health insurance plans do offer abortion coverage. This amendment would force private health insurance companies to abandon those policies, eliminate services, and limit a woman's options. The amendment does not, contrary to statements being made here on the floor, simply preserve the Hyde language that has been in place for more than three decades. Make no mistake, this amendment goes well beyond the concept of limiting Federal funds from paying for abortion. This amendment would make it impossible for a woman who pays for her premiums out of her own pocket to purchase a private health plan that offers her the right to choose what is best for her, for her health, and her family's well-being.

We have been working hard for a long time to eliminate discrimination

against women in our current health care system. Right now, our health care bill takes a balanced approach to abortion coverage. It preserves existing Federal law. Women have fought since this Nation's founding to have full rights under the law, including suffrage, including many other things. Unfortunately, this amendment would force them to take a step backward. I don't want to see it happen.

I urge my colleagues, please, use your judgment, make your own choices about your own family. Make your decisions as to what you would recommend to a daughter or a wife. But for God's sake, let the woman choose what is best for her.

I urge my colleagues to vote against the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, I rise in strong opposition to the Nelson-Hatch amendment. Let me start by saying that I support a woman's right of choice as a constitutionally affirmed right. I understand how difficult and divisive this issue is. That is why the underlying bill we have before us carries out the compromise that has already been reached between pro-choice and pro-life supporters. It represents maintaining the prohibition on Federal funds for abortion but allows a woman to pay for abortion coverage through use of her own funds. That is current law, and that is what the underlying bill makes sure we continue.

Many of us believe the health care debate is critically important. It is also controversial. Let's not bring the abortion issue into the bill. The Nelson-Hatch amendment would go beyond that. It would restrict a woman's ability to use her own funds for coverage to pay for abortions. It blocks a woman from using her personal funds to purchase insurance plans with abortion coverage. If enacted, for the first time in Federal law, this amendment would restrict what individual private dollars can pay for in the private insurance marketplace.

When you look at those who are supporting this amendment, you can't help but have some concern that this amendment is being offered as a way to derail and defeat the health care reform bill. Most of the people who are going to be supporting the amendment will vote in opposition to the bill. It is quite clear that the Senate health reform bill already includes language banning Federal funds for abortion services. So supporters of this bill are not satisfied with the current funding ban; they are trying to use this to move the equation further in an effort to defeat the bill. This is really wrong as it relates to women in America.

I am outraged at the suggestion that women who want an abortion should be able to purchase a separate rider to cover them. Why would we expect this overwhelmingly male Senate to expect women to shop for a supplemental plan

in anticipation of an unintended pregnancy or a pregnancy with health complications? Who plans for that? The whole point of health insurance is to protect against unexpected incidents.

Currently, there are five States—Idaho, Kentucky, Oklahoma, Missouri, and North Dakota—that only allow abortion coverage through riders. Guess what. The individual market does not accept this type of policy. It doesn't exist.

Abortion riders severely undermine patient privacy, as a woman would be placed in a position of having to tell her employer or insurer and, in many cases, their husband's employer that they anticipate terminating a pregnancy.

Also, requiring women to spend additional money to have comprehensive health care coverage is discriminatory. We don't do that for services that affect men's reproductive rights.

I hear frequently from my friends on the other side of the aisle that the statements we make; that is, those who support the underlying bill—that this allows individuals who currently have insurance to be able to maintain their insurance builds on what is good in our health care system. This amendment takes away rights people already have. So if you have insurance today as an individual that covers abortion services, if this amendment were adopted, you will not be able to get that. So we are denying people the ability to maintain their own current insurance, if this amendment were adopted.

It is the wrong amendment. The policy is wrong. But clearly, on this bill it is wrong.

I urge my colleagues to accept the compromise reached on this bill. Many of us who would like to see us be more progressive in dealing with this issue and remove some of the discriminatory provisions in existing law understand we will have to wait for another day to do that. Let's not confuse the issue of health care reform. Let's defeat this amendment that would be discriminatory against women. That is wrong.

I urge my colleagues to reject the Nelson-Hatch amendment.

I yield the floor.

**THE PRESIDING OFFICER.** The Senator from California.

**Mrs. BOXER.** Mr. President, I thank Senators MURRAY, LAUTENBERG, and CARDIN for participating in our half hour of debate. Our block of time has almost expired. I would like to close the half hour by saying one word that I think is a beautiful word, and that word is "fairness." "Fairness" is a beautiful word. It should always be the centerpiece of our work here. We should never single out one group of people as targets. We should treat people the same.

It has been very clearly stated that the Nelson-Hatch amendment, like the Stupak amendment in the House, singles out an area of reproductive health care that only impacts one group, and

that is women. It says to women that they can't use their own private funds to buy coverage for the full range of reproductive health procedures. It doesn't say that to a man. It doesn't say to men: You can't use your own funds to cover the cost of a pharmaceutical product that you may want for your reproductive health. It doesn't say that they can't use their own private funds for a surgical procedure they may choose that is in the arsenal that they may choose for their own reproductive rights.

So we say to the men of this country: Look, we are not going to single out any procedure or any pharmaceutical product you may want to use for your reproductive health care. We are saying, if a private insurer offers it, you have the right to buy it. We are singling out women.

Again, let me say this as clearly as I can. We have had a firewall between the use of Federal funds and private funds. Senator REID has kept that firewall in place in the underlying bill. He keeps the status quo of the Hyde amendment. The group here who is coming on the floor continually—mostly men; I think so far all men; there may be some women who have spoken on their behalf, but I have not heard it—are basically saying: Forget the firewall. Forget it. Women, you cannot use your private funds, and government will tell you what you can or cannot do. I will tell you something. That is not what Uncle Sam should do. Uncle Sam should respect women, should respect men. I hope we defeat this amendment.

I yield the floor.

**THE PRESIDING OFFICER.** The Senator's time has expired.

The Senator from Wyoming.

**Mr. ENZI.** Mr. President, I yield up to 10 minutes to the Senator from Arizona.

**THE PRESIDING OFFICER.** The Senator from Arizona.

**Mr. KYL.** Mr. President, America's seniors have made clear they value the Medicare Advantage Program. They like their access to private plans, plan choices, lower cost sharing, and all the extra benefits not included in traditional Medicare, such as vision, dental, hearing, and the wellness programs that help them stay fit.

Before the Medicare Modernization Act of 2003, seniors had been decrying their lack of choices. We made sure, under the Medicare Modernization Act, that seniors would be assured health care choices, just as all of us here in the Congress enjoy.

Now that they have access to private coverage and enjoy more benefits and choices, seniors want us to make sure Medicare Advantage stays viable, and they are not happy about the proposed cuts in the majority leader's bill.

I have received more than 500 phone calls since November 1 from constituents who oppose the \$120 billion Medicare Advantage cuts proposed by the majority's bill. They know you cannot

cut \$120 billion from a program without cutting its benefits. A lot of seniors in Arizona are asking, What happened to the President's repeated promise that if you like your insurance, you get to keep what you have? They do not like the idea that under this bill their benefits would be slashed by 64 percent, from \$135 of value per month to \$49 of value per month, which is exactly what the Congressional Budget Office projects would happen. They do not want the money they paid into Medicare going to fund a new government entitlement program for nonseniors. They are not satisfied with the majority's promise to protect "guaranteed" benefits. They want Members of Congress to be straight about our intentions and not engage in semantics. They want an unequivocal promise they will be able to keep exactly what they have now, just as the President promised.

Here is the problem. There is an earmark buried on page 894 of the legislation before us that suggests that senior citizens in Florida must have insisted on this exact kind of protection for their Medicare Advantage as well.

This provision, in section 3201(g), was specifically drafted at the request of the senior Senator from Florida to protect the benefits for at least 363,000 Medicare Advantage beneficiaries in Florida but very few anywhere else. Nothing in the bill grants the same protection that is granted to these senior citizens to those in my State or in the other States in which there are a lot of seniors who have the Medicare Advantage Program.

That is why I support the motion of my colleague, Senator MCCAIN, to commit this bill to the committee and return it without these—actually, what his bill does is to ensure that all seniors, whatever State they are in, enjoy the same grandfathering status as the senior citizens in Florida would have under the Nelson proposal.

The McCain motion to commit is straightforward. First of all, it would help the President keep his commitment that seniors get to keep their insurance if they like it. And it applies to all of America's seniors the same protection granted to Floridians, as I said. Isn't that what all seniors deserve, the security of knowing their current benefits are safe? If our Democratic colleagues are not willing to extend this protection to every Medicare Advantage beneficiary, then I cannot imagine how they can claim to be in favor of protecting Medicare.

I have been sharing letters that I have received from Arizona constituents describing what the Medicare Advantage Program means to them. I thought today I would share some excerpts from a few more of these letters.

A constituent in Surprise, AZ—I hope the Presiding Officer likes the name of that town: Surprise, AZ—just west of Phoenix, says:

I truly hope you will consider keeping the Medicare Advantage plans for seniors. I find the savings a must on my fixed income.

I appreciate the [high quality] doctor care on my MediSun Advantage plan. Prescriptions are included in the cost of my plan, providing further savings for me. Medicare Advantage has made a real difference in my life. Please don't let anything happen to this important program.

A constituent from Fountain Hills, AZ, writes:

I suffer from a specific type of amyotrophic lateral sclerosis, and rely on Medicare Advantage for all of my medical needs. I am asking that you do all that is in your power to protect and provide for the continued funding of this program. In Arizona, we have over 329,000 people who count on Medicare Advantage. Our lives would be devastated without it.

A constituent from Wickenburg, AZ, says:

Please don't let anything happen to my Medicare Advantage. I like my Medicare Advantage plan because I can choose my own doctor in my own town and also choose a specialist if I need one.

I can also get regular check-ups and don't have trouble getting to see the doctor. So, I ask that you don't let the government cut my Medicare Advantage.

A constituent from Mesa, AZ, says:

I am a senior citizen. I am becoming more and more concerned about President Obama's healthcare plans, and I am writing to tell you that I am happy with my Medicare Advantage plan. I request that you do all you can not to cut my benefits.

I have a fairly wide choice of doctors and specialists, who have always treated me with respect, given me the time I feel I need, and have given me excellent care.

I have a fitness benefit, which entitles me to the Silver Sneakers program at our local YMCA; two choices of a dental plan; a vision plan; plus many other options to maintain my level of health or to try to improve it.

Please, I beg you, do whatever you can to maintain our Medicare Advantage plan. Do NOT cut any of our benefits.

We know there are millions of seniors out there who absolutely depend on Medicare Advantage. Many have stories to tell about how this program has improved the quality of their life and their health. I urge my colleagues to support the McCain motion to commit to ensure that all of America's seniors, not just those in certain preferred counties, primarily located in the State of Florida, are grandfathered in these benefits.

Again, to make it very clear, Medicare Advantage benefits are cut by the \$120 billion reduction in Medicare under the bill. The Senator from Florida found a way to grandfather the Medicare Advantage benefits for many of his constituents. What the McCain motion to commit does is to apply that same grandfathering to all seniors in all States so that none of the seniors who have Medicare Advantage today would lose any of the benefits they enjoy today.

It seems to me what is good for our senior citizens in Florida ought to be good for our senior citizens in Arizona or any other State in which they reside. I urge my colleagues to consider and to support the McCain motion to commit.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I yield up to 10 minutes to the Senator from Ohio, Mr. VOINOVICH.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. VOINOVICH. Mr. President, I want to spend a minute discussing the very emotional and divisive issue of abortion. I personally believe that all children, born or unborn, are a precious gift from God, and we have a moral responsibility to protect them. It grieves me to think that there have been more than 40 million abortions performed in this country since 1973.

I am pleased to support the Nelson amendment that would apply the long-standing Hyde amendment, which currently prohibits Federal funding to pay for abortion services except in cases of rape, incest, or to save the life of the mother, to the health care reform bill.

The issue of abortion is one that results in very strong emotions on both sides of this issue. Because of the concerns that millions of Americans have with using Federal taxpayer dollars for abortion, Congress enacted the Hyde amendment. As my colleagues know, the Hyde amendment has restricted Federal Medicaid dollars from paying for abortion services since 1977, and has been applied to all other federally funded health care programs, including the Federal Employees Health Benefits Program.

Think about that, this language has been in place since the Ford administration, and has survived through the administrations of Presidents Carter, Reagan, George H.W. Bush, Clinton, and George W. Bush. That is 33 years, and all of a sudden, my colleagues want to change our policy on Federal funding of abortion.

We shouldn't be making this type of sweeping policy change in the health care legislation, and the Nelson amendment is a necessary addition to the bill in order to protect our current policy and the unborn.

I understand that not everyone in this country agrees with my position on abortion, but I am deeply concerned about the possible implications of spending taxpayer dollars on abortions when the issue so deeply divides Americans on ethical grounds.

While as I have said, I don't agree with abortion and believe *Roe v. Wade* should be overturned, the Nelson amendment does not prohibit anyone from seeking an abortion, it does not overturn *Roe v. Wade*, and it does not place any new restrictions on access to abortions.

It simply ensures that the taxpayer dollars will not pay for services that cause such deep moral divisions in our Nation. I think it is notable that this amendment is one of the few bipartisan amendments that the Senate will consider as part of this debate.

I am pleased that a similar amendment in the House of Representatives passed with a convincing margin, and I urge my colleagues to support the Nelson-Hatch amendment before the Senate.

I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from Wyoming.

Mr. ENZI. Mr. President, I yield up to 10 minutes to the Senator from Idaho, Mr. CRAPO.

Mr. CRAPO. Mr. President, I rise today to discuss the Medicare Advantage Program again. It is one that is facing nearly \$120 billion in cuts under the Democratic health care bill.

Currently, there are nearly 11 million seniors enrolled in Medicare Advantage, which is about one out of every four seniors in the United States. In my home State of Idaho, that is about 60,000 people or 27 percent of all Medicare beneficiaries in the State.

Medicare Advantage is an extremely popular program. In fact, it is probably the most popular and fastest growing part of Medicare. A 2007 study reported high overall satisfaction with the Medicare Advantage Program. Eighty-four percent of the respondents said they were happy with their coverage, and 75 percent would recommend Medicare Advantage to their friends or family members.

But despite the popularity of the program, the massive cuts in the Reid bill will result in most seniors losing benefits or coverage or both under Medicare Advantage.

I have a chart in the Chamber which I have shown before. You cannot see the individual States too well on it from this distance at this size, but you can see the coloring on the United States in this chart.

If you live in a State that is red, deep red, or the pinkish color—which is almost every State in the Union—then you are going to see your benefits cut under Medicare Advantage under this bill.

Why am I bringing it up again? We have already had a vote on it. In fact, we have had two votes on it. The majority has insisted on keeping these cuts in the bill. The reason I am bringing it up again is because, as we have combed through this 2,074-page bill, we have found out there is a provision in the Reid bill that would protect Medicare Advantage benefits for some people in the United States, for just a few in this country.

During the Finance Committee markup, Senator BILL NELSON of Florida advocated on behalf of Medicare Advantage and the beneficiaries in his home State of Florida. Subsequently, during closed-door negotiations, the legislative language was added to protect those beneficiaries.

This is interesting because one of the responses to us, as we have tried to stop the imposition of these cuts to Medicare, has been this bill will not cut any Medicare benefits. Well, if not, then why does Florida need a special exemption for its citizens? If not, why not support the McCain amendment that would give the same protection to all Medicare Advantage beneficiaries that the bill gives to primarily just a few in Florida?

Specifically, section 3201(g) of the Reid bill, very deep in the bill on page 894, has a \$5 billion provision drafted to prevent the drastic cuts in the Medicare Advantage Program from impacting those enrollees who reside primarily in three counties in Florida: Broward, Miami-Dade, and Palm Beach. It seems unfair that taxpayers would foot a \$5 billion provision that provides protection for only some of the Medicare Advantage beneficiaries. It certainly proves there are cuts to Medicare Advantage benefits in this bill; again, benefits that one out of four beneficiaries in America receives—one of the fastest, if not the fastest, growing parts of Medicare. Instead of preferential treatment for some, why not extend these same protections for Medicare Advantage to all beneficiaries under Medicare? I know the 60,000 Medicare beneficiaries on Medicare Advantage in Idaho, my home State, want and deserve that same level of protection.

That is why I am here to support the McCain motion to commit, and that is what his motion to commit would accomplish, very plain and very simple.

The McCain motion would extend this grandfathering provision to all beneficiaries in the Medicare Advantage Program so all seniors in this popular and successful program could maintain that same level of benefits that today they enjoy under the current law. Every senior in the Medicare Advantage Program deserves to keep these critical extra benefits, which include things such as dental protection, vision coverage, preventive and wellness services, flu shots, and much more.

In fact, most people who are not on Medicare Advantage in the Medicare Program have to buy supplemental insurance to get access to this coverage. Those in Medicare Advantage, which is one of the reasons it is such a popular program, have the opportunity to get it through their Medicaid services. Why is Medicare Advantage so opposed? Well, some say it is because of the extra costs, except that the extra costs in Medicare Advantage are returned to the government or shared with the beneficiaries. I think the reason might be because Medicare Advantage is one part of the Medicare Program that we have successfully been able to turn over to the private markets for operation. Interestingly, when the private sector gets involved in administering this part of the Medicare Program, the Medicare beneficiaries get more benefits, and it becomes the most popular program in Medicare.

I know my colleague from Pennsylvania, Senator CASEY, has filed an amendment to protect the 864,000 Medicare Advantage beneficiaries in his home State, and I would expect strong bipartisan support for the McCain motion to commit, since I think every Senator representing their constituents in their State wants to see this kind of protection. At the end, the

McCain motion to commit is simply an amendment that will protect nearly 11 million seniors today enrolled in the Medicare Advantage Program and help to keep the President's promise when he said if you like what you have, you can keep it. If this bill is not amended in the way it is being proposed to be amended by Senator MCCAIN's amendment, 11 million Americans are not going to be able to keep what they have in the Medicare Program, and that is just a start on the impact of what people in America are going to see under this legislation in terms of a reduction of their benefits and the quality of services they have access to.

I urge my colleagues to support this amendment, and I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. I yield myself the balance of the time.

AMENDMENT NO. 2962 TO AMENDMENT NO. 2786

Mr. President, I rise to speak in support of the Nelson amendment. We have been talking about the McCain amendment, which provides fairness for seniors who have Medicare Advantage so everybody across the country can have the same thing Florida is getting. But the critical amendment I wish to talk about is the Nelson amendment.

This amendment needs to be adopted if we truly want to prevent Federal dollars from being used to pay for abortions. I am asking my colleagues to support a Democratic amendment. This isn't a partisan issue; it is a human issue. Even if you are on the other side, I hope you can agree it is not right to force people to pay for a procedure they may find offensive to the core of their morality. This issue is very personal for many of us. It is for me.

When my wife Diana gave birth to our first child, Amy was 3 months premature. She weighed just 2 pounds and the doctor's advice was: Wait until morning and see if she lives. The doctors couldn't do anything to help this newborn baby. She survived the night.

The next day I took Amy to a hospital in Casper. An ambulance wasn't available so we went in a Thunderbird. It was in a huge blizzard, the same blizzard that prevented us to fly Amy to a hospital in Denver that specialized in that. But we took this car and went to the center of the State to the biggest hospital to get the best care we could find. We ran out of oxygen on the way because the snow slowed us. The highway patrol was looking for us, and they were looking for an ambulance. All along the way, we were watching every breath of that child.

We arrived at the hospital in Casper and put her in the care of doctors. There were several times when Diana and I went to the hospital and found her isolette with a shroud around it. We would knock on the window and the nurses would come and say: It is not looking good. We had to help her to breathe again or: Have you had your baby baptized? We did have Amy bap-

tized a few minutes after birth, as she worked and struggled to live. Watching an infant fight with every fiber of her being, unquestionably showing the desire to live, even though they are only 6 months developed, is something that will show you the value of life. Amy survived and is now a teacher so gifted she teaches other teachers.

Amy's birth changed my whole outlook on life. It reminded me of the miracle of life and the respect we owe that miracle. The Reid bill, as it is currently, does not respect life. But the amendment before us will allow that respect to be given to every American who benefits from that bill.

On September 9, President Obama told a joint session of Congress: "No Federal dollars will be used to fund abortions." I agree. No Federal dollars should ever be used to pay for abortions. To do otherwise would compel millions of taxpayers to pay for abortion procedures they oppose on moral or ethical grounds. Unfortunately, the Reid bill fails to meet that standard set by the President. Section 1303 of the bill provides the Secretary the authority to mandate and fund abortions.

Some have questioned exactly how this bill funds abortions. It is quite simple. The bill funds abortions through the government-run insurance option and through subsidies to individuals to help pay for the cost of private insurance. Both of these options are funded with Federal dollars. Under the community health insurance option, also known as the government-run plan, the Secretary of Health and Human Services could allow the plan to cover abortions. In addition, the new tax subsidies in the bill could also go to private plans that cover abortions. In both these cases, Federal subsidies would be paid to plans that cover abortion.

The Reid bill attempts to use budget gimmicks so its sponsors can argue that Federal funds will not pay for abortions. As the accountant in the Senate, I am not fooled by these gimmicks and neither should anyone else be. If the Reid bill is passed, Federal dollars will be used to pay for abortions.

Money is fungible. That is an interesting word. It means Federal dollars paid into a health plan could be shifted across accounts. We don't have a good accounting system for that. It can replace other spending and those dollars could then go to pay for abortions. There is no way to absolutely prevent Federal dollars from paying for abortions once they are paid to plans that cover abortions.

That is why Federal laws for the last 30 years have explicitly prohibited Federal funding going to such plans. That is right. It is already Federal law, although it comes in, in the appropriations bill, on an annual basis. Federal law currently prohibits funds going to pay for abortions under the Medicaid Program, under FEHBP—that is the program where we get our health insurance; it is the one that provides all the

health insurance for all Federal employees, the same choices of plans—and the TRICARE Program, which is for all our Active military and their families.

Current law recognizes the only way to actually prevent Federal funds from being used to pay for abortion is to offer the coverage of abortion in separate insurance plans and collect separate premiums to pay for that plan. This is what States who want to cover abortion for their Medicaid populations already do. As I said earlier, Medicaid is prohibited from using Federal dollars to pay for abortions. As a result, States set up separate plans and collect non-Federal dollars in separate accounts to pay for those services.

If anyone has any doubts about the impact of the Reid bill, I would point them to the comments made by the senior staff at the U.S. Conference of Catholic Bishops. The associate director, Richard Doerflinger, recently described the Reid bill as “completely unacceptable” and said it was the worst health reform bill they had seen so far on life issues.

It is probably worth it to note that the bishops have been longtime supporters of health care reform and covering the uninsured. Similarly, National Right to Life said the Reid bill “seeks to cover elective abortions in two big new Federal health programs, but tries to conceal that unpopular reality with layers of contrived definitions and hollow bookkeeping requirements.”

There has also been some misinformation out there regarding this amendment, and I wish to take a minute to clear up a couple arguments used against the Nelson amendment. First, it does not prohibit individuals from purchasing abortion coverage with their own private dollars. When similar arguments were made during the House debate on the Stupak language, *PolitiFact*, a Pulitzer Prize-winning, fact-checking organization, concluded that such statements were false. The Nelson amendment only prohibits Federal funds from subsidizing those plans.

Some have argued the Nelson amendment could cause individuals to lose the abortion coverage they currently receive from their current health insurance plans. That also isn't accurate. I would urge everyone to read section 1251 of the bill. Section 1251 says, clearly and unequivocally, that:

Nothing in this act or an amendment made to this act shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled at the date of the enactment of this act.

According to the sponsors of this bill, this section protects the ability of persons with existing insurance coverage to keep that same coverage. If section 1251 works as its authors describe it, this bill should make no changes to existing insurance plans that cover abortion and should allow individuals to keep the plans they have.

Some have also said this amendment would ban abortion procedures. That, too, is false. The amendment does not ban abortions; it simply prohibits Federal dollars from paying for abortions, which is consistent with the current law.

Many of my Democratic colleagues have argued during the debate that the health care we provide under this bill should be as good as the coverage given to Senators. If they believe that, they should all support applying the same rules regarding abortion coverage that apply to our own health plans. Federal employees' plans are prohibited from covering abortion—all Federal employees, not just Senators.

I will work hard to see that taxpayers are not compelled to fund abortion services. I believe those of us in elected office have a duty to work to safeguard the sanctity of human life, since the right to life was specifically named in the Declaration of Independence. By safeguarding our right to life, our government fulfills the most fundamental duty to the American people. When that right is violated, we violate our sacred trust with our Nation's citizens and the legacy we leave to future generations.

Regardless of what some people think, God doesn't make junk. He makes people in a variety of sizes, shapes, and abilities, and disabilities. There is a purpose even if we cannot understand it. I like the sign just outside Gillette. It says: “If it's not a baby, you're not pregnant.”

I don't believe Federal funding should be used to pay for abortions, and I will work to ensure that it doesn't happen under this bill. I will vote in support of the Nelson amendment and encourage my colleagues to do the same to protect life and respect the miracle of life that I witnessed with the birth of my daughter Amy.

I thank the Chair and yield the floor. The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. BOXER. Mr. President, I ask unanimous consent for the following order: Boxer, 1 minute; Durbin, 5 minutes; Stabenow, 5 minutes; Shaheen, 5 minutes; Dodd, 5 minutes; Menendez, 5 minutes; and Baucus, 4 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mrs. BOXER. Mr. President, I gave birth to two beautiful children, and I am proud to say that I have now four grandchildren—the light of my life. I am just here to say as a mother, as a grandmother, and as a Senator from California that I trust the women of this country. I don't want to tell the women of this country—or tell anybody else anything like this—that they can't buy insurance with their own private money to cover their whole range of legal reproductive health care. We don't do that to the men. We don't say they can't get any surgery if they might need it for their reproductive health care. We don't tell them they

can't get certain drugs, under a pharmaceutical benefit, they may need for their reproductive health care. Imagine if the men in this Chamber had to fill out a form and get a rider for Viagra or Cialis and it was public. Forget about it. There would be a rage in this Chamber.

We are just saying treat women fairly. Treat women the same way you treat men. Let them have access to the full range of legal reproductive health care. That is all we are saying. Vote no on this amendment, the Nelson-Hatch amendment, because HARRY REID takes care of the firewall between private funds and Federal funds. We keep that firewall.

Is it OK if Senator DURBIN goes after Senator STABENOW?

Mr. DURBIN. Yes.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I thank the Senator from California for her passionate advocacy and standing up for all of us, the women of this country. She is a mom, as she said. I, too, am a mom. As hard as it is for me to believe, I am also a grandmother with wonderful 2-year-old Lily and a little grandson Walter, who was born on his daddy's—my son's—birthday in August. Obviously, they are the light of my life, as well.

One of the reasons I feel so passionate about the broader bill on health care reform is that this is about extending coverage to babies so they can be born healthy, and about prenatal care; it is about making sure that in the new insurance exchange we have basic coverage for maternity care. I was shocked to learn that 60 percent of the insurance policies offered right now in the individual market don't offer maternity care as basic care. We happen to think that is incredibly important. We are 29th in the world in the number of babies—below Third World countries—that survive the first year of life. This health care reform bill is about making sure we have healthy babies, healthy moms, and it is about saving lives and moving forward in a way that is positive, expanding coverage, not taking away important coverage for women who, frankly, find themselves in a crisis situation.

That is what we are doing, unfortunately, through the Nelson-Hatch amendment. I have great respect for both of my colleagues who have offered this amendment, and for others who feel deeply about this issue. In the bill that has come before us, I think we respect all sides and keep in place the longstanding ban on Federal funding for abortion services, and no one is objecting to that. No one is trying to change that.

As my friends have said, this is about whether we cross that line into private insurance coverage—whether we say to a woman, to a family: You are going to have to decide whether, when you have a child and you are having a crisis in the third trimester and might need

some kind of crisis abortion services—whether you are going to find yourself in a situation where you are going to need abortion services, and you are going to have to publicly indicate that and buy a rider on insurance because you can't use your own money to buy an insurance policy.

Here is what we know now. We know five States have riders right now—Idaho, Kentucky, Oklahoma, Missouri, and North Dakota. There is no evidence there are any riders available in the individual market. So even though, technically, they say you can buy additional coverage, it is not offered or available. We are told by the insurance carriers that, in fact, it probably will not be available.

We all know what this is about. This is about effectively banning abortion services coverage in the new insurance exchange we are setting up, which could, in fact, have a broader implication of eliminating the coverage for health plans outside the exchanges. So that is what this is about, which is why it is so important.

Again, we are agreeing on the elimination or banning of Federal funding for abortions, other than extreme crises circumstances. We have done that in Federal law. This is about whether we go on to essentially create a situation where effectively people cannot get that coverage with their own money.

The Center for American Progress noted that because approximately 86 percent of the people who are going to be offered new opportunities for insurance—small businesses, individuals, in the private market—that because 86 percent of them will, in fact, receive some kind of tax credit or tax cut, in fact, again, we are talking about eliminating this option altogether because the majority of people will get some kind of a tax cut during this process.

I think there are also some broader implications around the tax policy. If we are saying that someone can't purchase an insurance policy of their liking if they are getting a tax credit to help with health insurance, the fact is, what about other tax credits? What about other kinds of ways in which people get tax credits or tax cuts today? The implications of this are extremely broad.

I urge a "no" vote. Let's keep Federal policy in place that doesn't allow Federal funding for abortion but respects the women of this country.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I rise in opposition to the Hatch-Nelson amendment. For 27 years, it has been my honor to serve in both the House and Senate. During that 27 years, the issue of abortion has been front and center as one of the most controversial and contentious issues we have faced. When I returned home to my congressional district, and now to the State, there have been many strong, heartfelt positions on this issue that are in conflict.

Members of the Senate and House meet with people who have varying degrees of intensity on this issue all the time. We are not going to resolve this issue today with this amendment or this bill. We are going to do several things that I think are important.

What we set out to do in health care reform was honor the time-honored principles that we have now accepted. They are these: Abortion is a legal procedure since the Supreme Court case of *Roe v. Wade*. For over 30 years now, we have said no public funds can be used for an abortion but to save the life of a mother or in cases of rape or incest. We have said that no doctor or hospital will be compelled to perform an abortion procedure if it violates their conscience. Those are the three basic pillars of our abortion policy in this country.

Now comes this debate about health care reform and a question about whether, if we offer health insurance policies through an exchange that offers abortion services, and the people are paying for the premiums for those policies with a tax credit, whether we are indirectly somehow or another financing and supporting abortion. I argue that we are not. We find, on a daily basis, many instances where Federal funds go to a private entity, even a religious entity with clear guidelines that none of the Federal funds can be spent for religious or private purposes.

Organizations far and wide across America live within those bounds. They keep their books clean, and they account for the money received, and no questions are asked. The audits show that they followed the guidelines. This bill before us strictly follows these guidelines, as well. No Federal funds shall be used for any abortion procedure in an insurance policy. It has to be privately funded.

I want to step back and make a slightly different argument too. There are those who have said in the House and in the Senate that unless the Stupak language in the House is adopted, they would seriously consider voting against health care reform. I argue to them that is a wrong position to take if they are opposed to abortion because the health care reform bill before us dramatically expands health care coverage.

Today, there are 17 million women of reproductive age in America who are uninsured. This bill will expand health insurance coverage to the vast majority of them, which means millions more women will have access to affordable birth control and other contraceptive services. This expanded access will reduce unintended pregnancies and reduce abortions. So the family planning aspect of our health care reform will actually net fewer abortions in America—we know this because of the history of the issue—as more women have access to family planning. So those who argue that they either have this amendment or they will vote against health care reform should reflect on

the fact that there will be fewer abortions in America with these health care services.

Senator MIKULSKI, in the first amendment we adopted, provided for more preventive services for women across the board. Those services, I believe, would result in more counseling, more contraception, and fewer unintended pregnancies. That is a reality. Every Federal dollar that we spend on family planning saves \$3 in Medicaid costs. In 1972, we established a special matching rate of 90 percent for family planning services in Medicaid. Across the board, we know this money, well spent to allow women to decide their own reproductive fate, means there are fewer unintended pregnancies.

I argue that whether your position is for or against abortion, if you believe there should be fewer abortions, you want this health care reform bill to pass—with or without the Stupak amendment. I think that the Stupak amendment goes too far, and I think we have come up with a reasonable alternative that adheres to the three pillars I mentioned earlier on abortion policy in America, and it sets up reasonable accounting on these insurance policies. I think this language in the bill is the right way to move to lessen the number of abortions in America and stay consistent with the basic principles that guide us.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I commend my colleague from Illinois, the Democratic whip of the Senate, for his arguments. He speaks for me when he identifies the pillars of our views on this issue.

I was elected to the House of Representatives in 1974, 2 years after *Roe v. Wade*, and I have been in Congress now for 35 years. We have lived with those guidelines since then. I know it has not resolved the matter for many people. But it has served us well.

What we have in this bill is a reflection of a continuation of those pillars. Having been the acting chair of the Health, Education, Labor, and Pensions Committee during the markup of the bill—in fact, Senator Kennedy voted by proxy, as they call it in that process—we insisted upon the adoption of a Kennedy amendment that maintained the notion of conscience in these matters. So we would not be forcing individuals to engage in abortion practices if they felt otherwise.

We have long held the view in this Congress, under Democratic and Republican leadership, despite the differences—others have different views on this matter—that clearly public money should not be used. Despite the arguments to the contrary, we have done that again with this bill.

The Senator from Illinois made a point about the measures in the bill that deal with wellness and reproductive rights. We minimize the likelihood of there being a demand for abortion on the part of many.

I appreciate the fact that our leadership has made this matter, the Nelson-Hatch amendment, a matter of conscience. There is no caucus position on this amendment. There never has been and nor should there be, in my view, given the nature of this debate.

I want to mention another argument we fail to understand here, in addition to the eloquent ones made by the Senator from Illinois. We rank 29th in infant mortality in the United States. It is an incredible statistic when you consider the wealth of our Nation. I worked on legislation with our colleague, LAMAR ALEXANDER, on infant births, prescreening, trying to provide resources and help for families with infants who suffer these debilitating and fatal problems.

This legislation takes a major step forward in taking the United States out of the basement when it comes to infant mortality and gets us back to where we ought to be in reducing the tragedy that occurs in infant mortality.

There is a distinction, clearly, between abortion and infant mortality. But this legislation takes a major step in improving quality of life, assisting children who arrive prematurely, as many do in our country today, and many do not survive that prematurity. Today many women are not getting the kind of support they need during their pregnancy, thus increasing the likelihood of premature births occurring, or not getting the screenings that need to occur immediately so you can avoid the terrible problems that can ensue thereafter. This legislation takes a major step in that direction.

While we have done what is necessary for us to do, that is, protect the long-standing distinction between public and private dollars when it comes to abortion, we also have gone so much further. This bill provides support for families when it comes to minimizing the likelihood a child will be lost because they are not getting support services, as well as providing the reproductive services that will assist women during their pregnancies.

My colleagues know I am a late bloomer. I am a parent of a 4-year-old and an 8-year-old. My colleagues talk about being grandparents. I always said I was the only candidate in the country who used to get mail from AARP and diaper services at the same time, having qualified for Medicare and also being a parent of infant children, two little girls, Grace and Christina. I want them to grow up having all the rights of young women in this country. I am hopeful that one day I may even be around to be a grandparent. We fought very hard to make sure those children were going to get the protections they could during my wife's pregnancies, to see to it they would be born healthy and sound. I have a great health care plan, as a Federal employee, to make sure that will happen. I want every American to have that same sense of security when that bless-

ing occurs with the arrival of a child or grandchild. This bill does that.

For all of those reasons, this amendment ought to be defeated. This bill ought to be supported and achieve a great success for our fellow citizens.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mrs. SHAHEEN. Mr. President, I rise today to speak in opposition to the Nelson-Hatch amendment.

The Patient Protection and Affordable Care Act we have before us does so many good things. It gives women access to preventive care. It makes health care more accessible to families across the country. It changes the way patients receive the care they need. We must not let the issue of reproductive choice overshadow all of the things this bill gets right.

For over three decades, the Hyde amendment, which prohibits the use of Federal funds to pay for abortions except in cases of rape, incest, or if the life of the mother is at risk, has been the law of this land. Abortion should play no role in this health care debate. The Finance and HELP Committees spent countless hours drafting legislation that is part of the language in our health care bill to make sure it remains neutral on the issue of choice.

The Patient Protection and Affordable Care Act that is currently before us maintains the Hyde amendment prohibiting Federal funding of abortions. As a result, neither the pro-choice nor the pro-life agendas are advanced.

This is clearly explained in an analysis done by the nonpartisan Congressional Research Service. I ask unanimous consent to have printed in the RECORD this analysis.

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

NOVEMBER 30, 2009.

MEMORANDUM

To: Hon. Jeanne Shaheen.

From: Jon O. Shimabukuro, Legislative Attorney, American Law Division, Congressional Research Service.

Subject: Abortion and the Patient Protection and Affordable Care Act.

This memorandum responds to your request concerning abortion and the Patient Protection and Affordable Care Act. The measure was proposed by Senator Harry Reid on November 21, 2009 as an amendment in the nature of a substitute for H.R. 3590, the Service Members Home Ownership Tax Act of 2009. You asked several questions about the Patient Protection and Affordable Care Act and the use of federal funds to pay for abortion services. This memorandum addresses those questions.

1. "Does the Senate's Patient Protection and Affordable Care Act prohibit affordability and cost-sharing credits from paying for abortions beyond those permitted by the most recent appropriation for the Department of Health and Human Services?"

Division F of the Omnibus Appropriations Act, 2009, provides appropriations for the Departments of Labor, Health and Human Services, Education, and Related Agencies for FY2009. Section 507, included within Division F, prohibits generally the use of appropriated funds to pay for abortions:

(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

This restriction on the use of appropriated funds to pay for abortions is commonly referred to as the "Hyde Amendment." In 1976, Rep. Henry J. Hyde offered an amendment to the Departments of Labor and Health, Education, and Welfare, Appropriation Act, 1977, that restricted the use of appropriated funds to pay for abortions provided through the Medicaid program.

An exception to the general prohibition on using appropriated funds for abortions is provided in section 508(a) of the omnibus measure:

The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

In other words, funds appropriated to the Department of Health and Human Services ("HHS") for FY2009 could be used to pay for an abortion if a pregnancy is the result of an act of rape or incest, or if a woman's life would be endangered if an abortion were not performed. Appropriated funds remain unavailable, however, for elective abortions.

Under the Senate measure, the issuer of a qualified health plan would determine whether or not the plan provides coverage for either elective abortions or abortions for which the expenditure of federal funds appropriated for HHS is permitted. If a qualified health plan decides to provide coverage for elective abortions, it could not use any amount attributable to a premium assistance credit or any cost-sharing reduction to pay for such services. The community health insurance option established by the Senate measure would be similarly restricted. H.R. 3590 would allow coverage for elective abortions by the community health insurance option, but amounts attributable to a premium assistance credit or cost-sharing reduction could not be used to pay for such abortions.

2. "Does the Senate's Patient Protection and Affordable Care Act ensure that the community health insurance option does not use federal funds to pay for abortions beyond those permitted by the most recent appropriation for the Department of Health and Human Services?"

The Senate measure would allow coverage for elective abortions by the community health insurance option, but amounts attributable to a premium assistance credit or cost-sharing reduction could not be used to pay for such abortions.

3. "Under current law, the Weldon Amendment prohibits Federal agencies or programs and State or local governments who [sic] receive certain federal funds from discriminating against certain health care entities, including individuals and facilities, that are unwilling to provide, pay for, provide coverage of, or refer for abortions. Does the Senate's Patient Protection and Affordable Care Act offer an additional, new conscience protection for individual health care providers

and facilities that are unwilling to provide, pay for, provide coverage of, or refer for abortions?"

Under the Senate measure, individual health care providers and health care facilities could not be discriminated against because of a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions, if their decisions are based on their religious or moral beliefs. Section 1303(a)(3) of the Senate measure states: "No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions."

4. "Does the Senate's Patient Protection and Affordable Care Act ensure that there is a health plan available in every exchange that does not cover abortion beyond those permitted by the most recent appropriation for the Department of Health and Human Services?"

The Senate measure would require the Secretary of HHS to ensure that in any health insurance exchange ("Exchange"), at least one qualified health plan does not provide coverage for abortions for which the expenditure of federal funds appropriated for HHS is not permitted. If a state has one Exchange that covers more than one insurance market, the Secretary would be required to provide the aforementioned assurance with respect to each market.

Mrs. SHAHEEN. Mr. President, the health reform legislation before us preserves the Hyde language and maintains the status quo in this country. We should keep it so. This should be a debate about health care. It should be about patients and about ensuring they have access to quality care at all stages of their lives, regardless of what may happen in their lives. It is a mistake to make this debate one about abortion.

The amendment that is before us, the Nelson-Hatch amendment, would restrict any health plan operating in the exchange that accepts affordability credits from offering abortion services. In essence, the amendment before us would amount to a ban on abortion coverage in the health insurance exchange regardless of where the money comes from. Put another way, a woman who pays for insurance with money out of her own pocket would most likely not be able to get insurance that covers abortion.

Make no mistake about it, this amendment is much more than a debate on whether Federal funds should be used for abortion, which is already established law. It is established law that is maintained in the Patient Protection and Affordable Care Act before us.

The Nelson-Hatch amendment is a very far-reaching intrusion into the lives of women in how we would get private insurance. It is unprecedented, and it would mean millions of women would lose coverage they currently have.

It is true, as we have heard from those people who support this amendment, that a woman would be able to buy an abortion rider. What we heard from Senator STABENOW and what we

have seen from the National Women's Law Center shows us that in the five States that do require such a rider, there is no evidence that such plans exist. And even if they did exist, who would purchase that kind of a rider? No woman expects to need an abortion. This is not something you go into planning ahead of time.

Finally, this amendment would have effects that reach well into the private insurance market. An independent analysis by the School of Public Health and Health Services at George Washington University concluded that a similar amendment adopted in the House—what is commonly known as the Stupak amendment—will have an "industry-wide effect," eliminating coverage of medically indicated abortions over time for all women." That means any type of abortion for which there is a medical indication of need would go uncovered.

I ask unanimous consent that "Introduction and Results in Brief" of the George Washington University analysis be printed in the RECORD.

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

AN ANALYSIS OF THE IMPLICATIONS OF THE STUPAK/PITTS AMENDMENT FOR COVERAGE OF MEDICALLY INDICATED ABORTIONS

(By Sara Rosenbaum, Lara Cartwright-Smith, Ross Margulies, Susan Wood, D. Richard Mauery)

INTRODUCTION AND RESULTS IN BRIEF

This analysis examines the implications for coverage of medically indicated abortions under the Stupak/Pitts Amendment (Stupak/Pitts) to H.R. 3962, the Affordable Health Care for America Act. In this analysis we focus on the Amendment's implications for the health benefit services industry as a whole. We also consider the Amendment's implications for the growth of a market for public or private supplemental coverage of medically indicated abortions. Finally, we examine the issues that may arise as insurers attempt to implement coverage determinations in which abortion may be a consequence of a condition, rather than the primary basis of treatment.

Industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women: In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, we conclude that the treatment exclusions required under the Stupak/Pitts Amendment will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange. As a result, Stupak/Pitts can be expected to move the industry away from current norms of coverage for medically indicated abortions. In combination with the Hyde Amendment, Stupak/Pitts will impose a coverage exclusion for medically indicated abortions on such a widespread basis that the health benefit services industry can be expected to recalibrate product design downward across the board in order to accommodate the exclusion in selected markets.

Supplemental insurance coverage for medically indicated abortions: In our view, the terms and impact of the Amendment will work to defeat the development of a supplemental coverage market for medically indi-

cated abortions. In any supplemental coverage arrangement, it is essential that the supplemental coverage be administered in conjunction with basic coverage. This intertwined administration approach is barred under Stupak/Pitts because of the prohibition against financial commingling. This bar is in addition to the challenges inherent in administering any supplemental policy. These challenges would be magnified in the case of medically indicated abortions because, given the relatively low number of medically indicated abortions, the coverage supplement would apply to only a handful of procedures for a handful of conditions. Furthermore, the House legislation contains no direct economic incentive to create such a market. Indeed, it is not clear how such a market even would be regulated or whether it would be subject to the requirements that apply to all products offered inside the exchange. Finally, because supplemental coverage must of necessity commingle funds with basic coverage, the impact of Stupak/Pitts on states' ability to offer supplemental Medicaid coverage to women insured through a subsidized exchange plan is in doubt.

Spillover effects as a result of administration of Stupak/Pitts. The administration of any coverage exclusion raises a risk that, in applying the exclusion, a plan administrator will deny coverage not only for the excluded treatment but also for related treatments that are intertwined with the exclusion. The risk of such improper denials in high risk and costly cases is great in the case of the Stupak/Pitts Amendment, which, like the Hyde Amendment, distinguishes between life-threatening physical conditions and conditions in which health is threatened. Unlike Medicaid agencies, however, the private health benefit services industry has no experience with this distinction. The danger is around coverage denials in cases in which an abortion is the result of a serious health condition rather than the direct presenting treatment.

The remainder of this analysis examines these issues in greater detail.

OVERVIEW OF CURRENT FEDERAL LAW

1. The Hyde Amendment and Medicaid

The Hyde Amendment has been part of each HHS-related appropriation since FY 1977. As set forth in the most recent annual Labor/HHS federal appropriations legislation, the Hyde Amendment provides in pertinent part as follows:

Sec. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 508. (a) The limitation established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Mrs. SHAHEEN. When we pass this legislation that will reform our health care system, it should not be done in a way that would lose benefits for

women. All women should have access to comprehensive health care, including reproductive health care, from the provider of their choice.

I urge my colleagues to oppose any amendment that threatens reproductive care that women have counted on for over 30 years.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. MENENDEZ. Mr. President, health care reform legislation we are considering is good for America, it is good for women and for families. It is a health care reform bill; it is not an abortion bill. In fact, not a dime of taxpayers' money goes to subsidize abortion coverage in this bill. It is, in fact, abortion neutral.

This amendment, however, would change that. It would roll back the clock on a woman's right to choose. It unfairly singles women out and takes away benefits they already have. It singles out our daughters and legislates limits on their reproductive health, their reproductive rights. If we were to do the same to men, if we were to single out men's reproductive health in this legislation, imagine the outcry. Imagine if men were denied access to certain procedures. Imagine if they were denied access to certain prescription drugs. Imagine if the majority had to suffer the decision of the minority. But that is exactly what we are being asked to do to our daughters with this amendment—rolling back the hands of time. I personally find that offensive, as do women across this country.

The language of this bill has been carefully negotiated to ensure that we are preserving a woman's right to choose but doing so without Federal funding. To claim otherwise is hypocritical and misleading.

We need not fight all battles that have nothing to do with the real issue at hand—that millions of Americans do not have health insurance and many are being forced into debt to buy coverage that insurers later deny. But now, instead, we are not only reopening long-settled debates over this issue, we are actually faced with a proposal that would turn back the clock and deny women access to reproductive health care. It is the wrong debate at the wrong time.

Over the years, we have made extraordinary progress in addressing women's reproductive rights. We have debated this issue in the Senate. We have debated it in our churches, in our homes, in our communities, and in the U.S. Supreme Court that has said a woman's right to choose is the law of the land. Let's not turn back the clock.

I respect the deeply held views of my friend from Nebraska and the deeply held views of my friend from Utah. I know we will debate the issue many times in many forums. They will raise their voices in protest of a woman's right to choose, as I will raise mine to protect it. But this is neither the time nor the legislative vehicle for hot-button politics to get in the way of badly needed health care reform.

The language in this bill is clear: It preserves a woman's reproductive rights without any taxpayer funding. Yet we are engaged in a debate in which we are basically being told that neutrality is not good enough; that there needs to be an antichoice bill, not a health care reform bill; that neutrality on the issue is not acceptable; that only effectively banning abortion is acceptable. We are not going to be dragged down that road, and the women of this country will not stand for it. Certainly, this Senator will not either.

The sponsors claim the amendment simply reinforces existing law restricting Federal funding of abortion coverage. Let's be very clear: There is no taxpayer money going to a woman's reproductive choices—none—and to say otherwise is simply wrong.

The fact is, this amendment that clearly takes us back in time would leave our daughters with the same hopeless lack of options their grandmothers faced, and that is not where we ought to be.

This amendment would make it virtually impossible for insurance plans in the exchange to offer abortion coverage even if a woman were to pay premiums entirely out of her own pocket. It would do so by forbidding any plan that includes abortion coverage from accepting even one subsidized customer.

This amendment is nothing more than a backdoor effort to restrict rights women already have. Would I like to see it clearly stated in this legislation that a woman should have a right to choose and all aspects of her reproductive health should be available under every plan? Yes, I would. But am I willing to accept neutrality as a reasonable compromise for the sake of passage of a bill that will provide affordable, accessible health care to every American and not spend a dime of taxpayers' money on women's reproductive choices? I will.

Under this bill, if a plan chooses to provide abortion coverage, only private funds can go toward that care. That is further than I would like to go, but it is neutrality. In this bill, in each State exchange, there would be at least one plan that covers abortion and one plan that does not. That is neutrality. It is fair. Let's accept it and move on.

Under this legislation, women will keep their fundamental right to reproductive health benefits and gain other benefits.

The PRESIDING OFFICER. The Senator has spoken for 5 minutes.

Mr. MENENDEZ. That is what we should do in terms of the underlying bill. Let's vote down this amendment. Let's not turn back the clock.

Mrs. BOXER. Mr. President, I ask unanimous consent that in lieu of Senator BAUCUS's 4 minutes, Senator CASEY take that time.

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

The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I rise in support of the Nelson amendment for two reasons, and I speak for myself, not for other Members of the Senate. Obviously, I know there is a good bit of disagreement on both sides and even within both sides of the aisle.

But I support this amendment for two reasons. One, I wish to make sure we ensure, through this health care legislation, the consensus we have had as part of our public policy for many years now—that taxpayer dollars don't pay for abortions. I believe we can and should and will get this right by the end of this debate.

The second reason I support this is, I believe it is important to respect the conscience of taxpayers, both women and men across the country, who don't want taxpayer dollars going to support abortions. If there is one or maybe two areas where both sides can agree—people who are pro-life and pro-choice—it is on these basic principles: No. 1, we don't want to take actions to increase the number of abortions in America. I think that is the prevailing view across the divide of this issue. No. 2, we also have to do more to help those women who are pregnant, and I don't believe we are doing enough. We will talk more about that later. Even as we debate this amendment, the third thing I think we can agree on is, no matter what happens on this vote—and this debate will continue, even in the context of this bill—I believe we have to pass health care legislation this year.

There are all kinds of consumer protections in this bill that will help men and women—prevention services that have never been part of our health care system before, insurance reforms to protect families and, finally, the kind of security we are going to get by passing health care legislation for the American people. I believe we can get this decisive issue correct in this bill. We are not there yet, but I believe we can. I believe we must pass health care legislation this month through the Senate and then, from there, get it enacted into law.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, before we turn this over to the Republican side, I ask unanimous consent to have printed in the RECORD a letter from religious leaders who support maintaining the underlying bill and who oppose this amendment, and they are: Catholics for Choice, Disciples Justice Action Center, The Episcopal Church, Jewish Women International, Presbyterian Church Washington Office, Religious Coalition for Reproductive Choice, Union of Reform Judaism, United Church of Christ, Justice and Witness Ministries, United Methodist Church-General Board of Church and Society, Unitarian Universalist Association of Congregations.

We are proud to have their support for our position.

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

RELIGIOUS LEADERS SUPPORT MAINTAINING THE STATUS QUO ON ABORTION IN HEALTH CARE REFORM

The undersigned religious and religiously affiliated organizations urge the Senate to support comprehensive, quality health care reform that maintains the current Senate language on abortion services.

We believe that it is our social and moral obligation to ensure access to high quality comprehensive health care services at every stage in an individual's life. Reforming the health care system in a way that guarantees affordable and accessible care for all is not simply a good idea—it is necessary for the well-being of all people in our nation.

The passage of meaningful health reform legislation will make significant strides toward accomplishing the important goal of access to health care for all. Unfortunately, the House-passed version of health reform includes language that imposes significant new restrictions on access to abortion services. This provision would result in women losing health coverage they currently have, an unfortunate contradiction to the basic guiding principle of health care reform. Providing affordable, accessible health care to all Americans is a moral imperative that unites Americans of many faith traditions. The selective withdrawal of critical health coverage from women is both a violation of this imperative and a betrayal of the public good.

The use of this legislation to advance new restrictions on abortion services that surpass those in current law will serve only to derail this important bill. The Senate bill is already abortion neutral, an appropriate reflection of the fact that it is intended to serve Americans of many diverse religious and moral views. The bill includes compromise language that maintains current law, prohibiting federal funds from being used to pay for abortion services, while still allowing women the option to use their own private funds to pay for abortion care. American families should have the opportunity to choose health coverage that reflects their own values and medical needs, a principle that should not be sacrificed in service of any political agenda.

We urge the Senate to support meaningful health reform that maintains the compromise language on abortion services currently in the bill.

Respectfully,

Catholics for Choice, Disciples Justice Action Center, The Episcopal Church, Jewish Women International, NA'AMAT USA, National Council of Jewish Women, Presbyterian Church (U.S.A.) Washington Office, Religious Coalition for Reproductive Choice, The Religious Institute, Union of Reform Judaism, United Church of Christ, Justice and Witness Ministries, United Methodist Church—General Board of Church and Society, Unitarian Universalist Association of Congregations.

Mrs. BOXER. I thank the Chair.

Mr. ENZI. Mr. President, I assume that added a few additional minutes to our time as well.

I yield 10 minutes to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNIS. Mr. President, let me start my remarks today, if I could, by offering my words of support and commendation to Senators NELSON and HATCH for offering this amendment.

They have long been champions of the pro-life cause, and I applaud them for putting the time and effort into this amendment to get it right, bringing it to the floor, and offering it. I am very proud to stand here today as a cosponsor of this legislation.

Fundamentally, this legislation is simply about doing the right thing. It ensures that current Federal law is upheld. In its most basic form, it says taxpayer dollars are not going to be used, directly or indirectly, to finance elective abortions. In fact, this has been the law of our country now dating back three decades.

Basically, this amendment applies the Hyde amendment to the health care reform bill. It bars Federal funding for abortion, except in the case of rape, incest, or to protect the life of the mother. The Hyde amendment—as we have heard so many times during this debate—finds its genesis in 1977. The language in the Nelson-Hatch amendment is virtually identical to the Stupak language that was included in the House bill, where 240 Representatives in the House supported it and it passed on a vote of 240 to 194.

The Stupak language very clearly prohibits Federal funding of abortions. It says this: No. 1, the government-run plan cannot cover abortions. That seems very straightforward. No. 2, Americans who receive a subsidy cannot use it to buy health insurance that covers abortion. No. 3, the Federal Government cannot mandate abortion coverage by private providers or plans. Then, finally, No. 4, as has been the case for 30 years, private insurance plans may cover abortion, and individuals may purchase a plan that covers it, but taxpayer dollars cannot be in the mix to purchase that.

Compare that to what is in the current Senate bill. The government-run plan can cover abortion. Americans who receive a subsidy can use it to buy a health insurance policy that covers abortion. The Federal Government can and does mandate abortion coverage by at least one provider or plan. There is a stipulation in the current bill that requires the Health and Human Services Secretary to assure the segregation of funds, the tax credit/Federal dollars can't be used.

But the reality is, it is akin to saying: Here, put those Federal dollars in your left pocket. When you are purchasing the abortion coverage, make sure it is your right hand that is reaching into your right pocket. How do you segregate those funds? It is impossible. What it does is to simply erase the line between taxpayer dollars and funding of abortions.

Quoting the National Right to Life:

Senator Reid included in his substitute bill language that some have claimed would preserve the principles of the Hyde Amendment. Such claims are highly misleading. In reality, the Reid language explicitly authorizes direct funding of elective abortion by a Federal Government program.

Well, I feel very strongly we must ensure that Federal dollars are not used

to fund abortions directly or indirectly. Health care reform, under the Reid language, has become a vehicle for changing the current law of the land regarding abortion coverage. Here is what some of my constituents have said to me, and I am quoting from a gentleman in Kearney:

It is time to make sure that abortion is explicitly prohibited by any language that may be put forward.

Another Nebraskan said to me:

I know that the pro-life issue is not the only component of the Healthcare bill to consider, but it is probably the most important issue of concern that I have in this bill. Abortion is not health care.

From central Nebraska I heard this:

I'm taking a minute to send a note to say "thank you" for standing up for life. Life is precious, whether you are just conceived or over 100 years of age.

Pro-life groups across the board support this amendment—the National Right to Life, Catholic Bishops, Family Research Council, and others. They represent millions of Americans. But the reality is, Americans support this.

In a recent CNN survey, we confirm that 6 in 10 Americans favor a ban on the use of Federal funds for abortion. A recent Washington Post-ABC News poll indicates 65 percent of adults believe private insurance plans paid for with government assistance should not include coverage of abortion.

I was in McCook, NE, a while back, doing a townhall meeting in August. After everybody had left, a gentleman came up to me. He told me something about that I will remember all the years I am in the Senate. First, he spoke about his faith, and then he said: I hope you understand, Senator, I cannot, under any circumstances, agree to anything that would allow my taxpayer dollars, either directly or indirectly, to fund abortions. He said: I cannot go there. He said: Please, do everything you can to stop this from happening.

Today, I stand with that gentleman from McCook, NE, to say we have to stop this.

I applaud my colleague from Nebraska, and I wish to end my comments with this. Senator NELSON stood on this issue and in a recent interview he said this:

I have said at the end of the day, if it doesn't have the Stupak language on abortion in it, I won't vote to move it off the floor.

I think that is a courageous statement. I do not mind standing here and saying I am very pleased to associate myself with Senator NELSON and Senator HATCH on this important amendment.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 2 minutes 45 seconds.

Mr. JOHANNIS. I yield my 2 minutes 45 seconds to Senator HATCH when he speaks. I yield the floor.

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

Mr. GRASSLEY. Mr. President, I yield 10 minutes to the Senator from Kansas.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I appreciate this very much. It has been a healthy debate, a big debate, and it is an unusual debate because we haven't debated Hyde around here for 20 years. So this is an unusual debate we are having. Normally, we debate about abortion but not about abortion funding because there has been an agreement in this body for 33 years about that. So this is an unusual debate, but I think it is an important one.

I think it is extraneous, in many respects, to the health care bill itself. Abortion is not health care, and so why we are debating the funding of abortion in a health care bill seems odd to me. But it is in the base bill, and we need to deal with that.

A lot of people are coming forward and saying: Well, OK, which way is this; is it in the bill or not on funding for abortion? I am going to go to an independent fact checker and cite this. This is an independent research and prize-winning fact checker, PolitiFact.com, and they say our opponents' characterization of this amendment was "misleading" and that "the people who would truly pay all their premium with their own money, and who would not use Federal subsidies at all, not barred in any way from obtaining abortion coverage, even if they obtain their insurance from the federally administered health exchange."

That is an independent group, PolitiFact.com, saying this doesn't limit the ability for somebody on their own to be able to purchase abortion coverage, if they want to do that, but in the base bill, what we are saying is we don't want to put Federal funds in it as the longstanding policy has been here.

As the President himself has said when he spoke to a joint session of Congress, launching the health care debate:

One more misunderstanding I want to clear up—under our plan, no Federal dollars will be used to fund abortions, and Federal conscience laws will remain in place.

Unfortunately, in the Reid bill, this is not true. This is not true in the Reid bill. What is in the Reid bill is the so-called Capps amendment language, which allows for the Federal funding of abortion.

I wish to describe—and I think a great deal of what is in here has been described, but what is taking place is the Federal subsidization of an insurance program that will have abortion funding in it. According to most groups, that is what is taking place in the Capps language, which is in the base Reid bill.

I say this is an unusual debate that is taking place because we haven't debated Hyde for years around here. I wish to read to you what is our normal status on funding of abortions; that is,

that we don't do Federal funding of abortions. I will read to you what the normal status is. The U.S. Conference of Catholic Bishops, which supports this base bill but does not support funding of abortions, describes it this way:

In every major federal program where federal funds combined with nonfederal funds to support or purchase health coverage, Congress has consistently sought to ensure that the entire package of benefits excludes elective abortions. For example, the Hyde amendment governing Medicaid prevents the funding of such abortions not only using federal funds themselves, but also using the state matching funds that combine with the federal funds to subsidize the coverage. A similar amendment excludes elective abortions from all plans offered under the Federal Employees Health Benefits Program, where private premiums are supplemented by a federal subsidy.

So there it is prohibited as well.

Where relevant, such provisions also specify that federal funds may not be used to help pay the administrative expenses of a benefits package that includes abortions. Under this policy, those wishing to use state or private funds to purchase abortion coverage must do so completely separately from the plan that is purchased in whole or in part with federal financial assistance.

Here I take a quick aside. That is what we are saying should be done in this bill, but it is not what is done in this bill.

Going on:

This is the policy that health care reform legislation must follow if it is to comply with the legal status quo on federal funding of abortion coverage. All of the five health care reform bills approved in the 111th Congress violate this policy.

This is from a group, the United States Conference of Catholic Bishops, that supports health care reform but not the abortion funding in it. They say as well that this fails in the Reid bill, that there is explicit funding for abortion in this bill.

I thank my colleagues, particularly on the other side of the aisle, Senators NELSON and CASEY, for being major co-sponsors of this amendment. They are the ones who look at this and say: I don't want this in the base bill. This should not be in the base bill. It doesn't belong in the base bill. The language should be different.

I also wish to note that most people across the country don't want this in the base bill. A majority of the country is opposed to the bill overall. They don't think this is the way we should go. They think it is the wrong way. But even people who support the bill itself by and large don't want Federal funding for abortion to be in this bill.

A Pew poll even showed that 46 percent of people who support health care reform want to see the radical abortion language removed, the Capps language in the Reid bill, and all pro-choice Republicans and several pro-choice Democrats supported the measure in the House that put Stupak language in that removed the Federal funding for abortion. The American people feel this way because they know that forc-

ing Federal funding of abortion is fiscally irresponsible and morally indefensible. Those are the two central pieces we are discussing, the fiscal responsibility or irresponsibility of this and the moral indefensibility. At a time of hemorrhaging debt, the Federal Government being supportive and funding elective abortions flies in the face of trying to restrain or bend the cost curve down in this legislation. That is not us being fiscally responsible.

I have shown this chart before, but I think it is so striking. Back when we did do funding for abortions, we funded about 300,000 a year. How is that extra funding going to help us be more fiscally responsible? That is why a majority of the people, pro-life and pro-choice, are saying the Federal Government should not be funding this. I don't believe that is fiscally responsible. And it is morally indefensible.

Whether you are pro-choice or pro-life, we are having 300,000 children who are not going to be here that we are funding the elimination of. Under anybody's definition of looking at that, they would say that is morally indefensible for the Federal Government that has long debated abortion policy, has not debated abortion funding, that that is morally indefensible for us to do something along that line.

There are many issues to debate but thankfully Hyde has not been one of them we have been debating until now. I say to my colleagues the admonition we have had many times, whether you choose this day life or death, blessing or curse, why wouldn't we choose the life route on this one? Even if you have a close call or you are questioning this, why wouldn't we choose the route that says: I am not going to fund 300,000 abortions. I want abortion to be safe, legal and rare, as some people in this body, but that is not rare, 300,000. Why wouldn't we choose the life route that says this is a controversial issue sometime way in the past, not recently. We don't fund these things. So many people in America don't want their money used to pay for abortions. Yet in this base Reid bill, it is there. I urge my colleagues to vote in favor of the Nelson-Hatch-Casey amendment that puts into Hyde language that is the status quo that there is not taxpayer funding going toward abortion and to reject those who would put the Reid language forward that would take us back decades to an era when we did fund abortion procedures.

I yield the floor.

Ms. SNOWE. Mr. President, I rise today to voice my opposition to the Nelson-Hatch amendment. In deliberating how to construct a fair equitable solution to such a divisive question, the one thing that our Group of 6 agreed on during our meetings prior to the markup of legislation in the Finance Committee was that we wanted to remain neutral and preserve the status quo.

I am pleased that Majority Leader REID chose to reflect the Finance Committee's work because I believe that we

achieved that careful balance. Federal funds continue to be prohibited being used to pay for abortions unless the pregnancy is due to rape, incest or if the life of the mother is in danger. Health plans that choose to cover abortion care must demonstrate that no tax credits or cost-sharing credits are used to pay for abortion care.

The Finance Committee adopted this solution primarily because the policy of separating Federal dollars from private dollars has been achieved in other instances and there is a precedent for that approach. Today, 17 States cover abortion beyond the Hyde limitations with State-only dollars in their Medicaid Programs. States and hospitals, which in no way want to risk their eligibility for Medicaid funding, use separate billing codes for abortions that are allowable under the Hyde amendment, and those that are not. And let me emphasize, there have never been any violations among the States in this regard. Moreover, a similar approach has also been taken with Title X family planning funds and the United Nations Population Fund. We ought to hew to current law and what we know already works.

Yet some want to prohibit women from using their own money—beyond taxpayer dollars—towards purchasing a plan in the exchange that covers abortion or limit coverage only through a supplemental policy. I have strong reservations about taking such an approach.

Under the Nelson-Hatch amendment, a woman must try to predict whether or not she will require that coverage. This is an unfair proposition. Half of all pregnancies in this country are unplanned and most women do not anticipate the necessity for abortion coverage. Furthermore, in most cases, women already have that coverage. Today, between 47 and 80 percent of private plans cover abortion services. So for a middle income woman who already purchases coverage in the individual market and could now receive a subsidy, let me be clear about the effect this change would have. This would take away coverage she currently has essentially creating a two tiered system for women who don't have coverage through their employer and instead receive it through the exchange. That is fundamentally wrong, and it is patently unfair.

And the fact is, over time, more and more individuals will receive coverage through the exchange, which means that the number of women who will confront these restrictions will grow. Not only that but this amendment threatens to reach even further than the exchange. According to a study by the George Washington University School of Public Health that reviewed the Stupak/Pitts provisions from the House "the size of the new market is large enough so that Stupak/Pitts can be expected to alter the 'default' customs and practices that guide the health benefits industry as a whole,

leading it to drop coverage in all markets in order to meet the lowest common denominator in both the exchange and expanded Medicaid markets."

As opposed to the demonstrated evidence from States that separating Federal funds can and does work, we cannot say the same about the availability of supplemental, abortion-only coverage.

In the five States that have similar prohibitions on abortion coverage to the Nelson-Hatch amendment, supplemental coverage is generally not offered—as a result of a lack of market demand for riders. And even if supplemental coverage were available, there are significant privacy concerns. If a woman opted to purchase supplemental abortion coverage, it could be inferred that she plans to obtain an abortion. Confidentiality is vital to women who are making this choice and the possibility that this information could be disclosed is both serious and disturbing. Women may face harassment and intimidation on what should be a private matter between her family and her physician.

The fact of the matter is, whether to undergo an abortion is one of the most wrenching decisions a woman can ever make—and we shouldn't ignore the real life circumstances that lead them to this choice. For some expecting mothers, tragedy strikes when a lethal fetal anomaly is discovered. Other times there may be adverse health consequences to continuing a pregnancy. In these heartbreaking cases, a woman without coverage can face severe financial hardship in paying for these health costs—not to mention emotional anguish from ending a planned pregnancy.

Rather than focusing on abortion, we should concentrate on the significant obstacles women of child-bearing age face under our current health care system. And we have achieved some clear victories for women in this bill. For example, maternity and newborn care is specifically included as an essential health benefit. Pregnancy is typically the most expensive health event for families during their childbearing years and there are significant consequences in a lack of coverage or even minimal coverage. Maternity coverage in the individual insurance market is difficult to find and exceedingly expensive if it is available. Maternity coverage riders alone ranged from \$106 to \$1,100 per month, required waiting periods of one to 2 years with either no or limited coverage during that period and capped total maximum benefits as low as \$2,000 to \$6,000. Yet expenditures for maternity care average \$8,802.

I am also pleased that we passed the Mikulski amendment, which I was proud to cosponsor, that will enhance preventive services for women. This could include preconception care, where doctors counsel women on nutrition and other health interventions before they become pregnant, as well as proper prenatal care.

This is critical as mothers who receive no prenatal care have an infant mortality rate more than six times that of mothers receiving early prenatal care. Yet 20 percent of women of childbearing age are uninsured and approximately 13 percent of all pregnant women are uninsured.

This bill also at long last ends the discriminatory practice of gender rating. For years, women in this age group seeking insurance coverage have faced clear inequities compared to men. A study conducted by the National Women's Law Center found that insurers who practice gender rating charged 25-year-old women anywhere from 6 percent to 45 percent more than 25-year-old men, and charged 40-year-old women from 4 percent to 48 percent more than 40-year-old men. These critical improvements will enhance both access and health care outcomes for women. This is precisely the direction we should be heading in . . . rather than placing additional obstacles in front of women.

Throughout my tenure in Congress I have opposed Federal funding for abortion. At the same time, as a champion of women's health, I have profound reservations about limiting coverage options for women when they are contributing private dollars. Women who are subject to an individual mandate and are contributing private dollars to the cost of their insurance should not have coverage choices dictated for them by the Federal Government. We are making decisions that will affect women on an intensely personal level and if we fail to craft the right solution, it could have serious implications for women's health and privacy.

I appreciate the Finance Committee's effort to navigate this difficult issue and hope we can concentrate on the task at hand—providing coverage to the 30 million uninsured Americans. In that light, I urge my colleagues to vote against the Nelson-Hatch amendment.

The PRESIDING OFFICER (Mr. CASEY). Who yields time?

Mr. GRASSLEY. I yield such time as is remaining to the Senator from Utah.

Mr. HATCH. Mr. President, I had a longer statement I was going to deliver this afternoon, but after listening to my colleagues speak about the Nelson-Casey-Hatch amendment, I want to take my time to refute some of the arguments they are making about our amendment.

It does not even sound as though they are talking about the same amendment I filed with Senators NELSON and CASEY. Our amendment does nothing to roll back women's rights. When my colleagues on the other side say that, they are simply mischaracterizing our amendment. Our amendment ensures that the Hyde language, a provision that has been in the HHS appropriations legislation for the last 33 years, will apply to the new health care programs created through this bill. We are applying current law

to these programs. That is it. The current Hyde language ensures that no Federal Government funds are used to pay for elective abortion or health plans that provide elective abortion. Today States may only offer Medicaid abortion coverage if the coverage is paid for using entirely separate State funds, not State Medicaid matching funds. They cannot do that under current law. This is a longstanding policy based on a principle that the Federal Government does not want to encourage abortion.

For example, Guttmacher studies show that when abortion is not covered in Medicaid, roughly 25 percent of women in the covered population who would have otherwise had an abortion choose to carry to term. I wanted to explain why the Reid-Capps language in the Reid bill is not the Hyde language. First, the Hyde amendment prohibits funding for abortions through Medicaid and other programs funded through the HHS appropriations bill. However, the public option is not subject to further appropriation and therefore is not subject to Hyde. Directly opposite of the Hyde amendment, the Reid-Capps language explicitly authorizes the newly created public option to pay for elective abortions. The public option will operate under the authority of the Secretary of HHS and draw funds from the Federal Treasury account. Regardless of how these funds are collected, these funds from the Treasury are Federal funds. Funding of abortion through this program will represent a clear departure from longstanding policy by authorizing the Federal Government to pay for elective abortion for the first time in decades.

The Nelson-Hatch-Casey amendment would prohibit funding for abortion under H.R. 3590 except in the cases of rape, incest, or to save the life of the mother. As is the case with the CHIP program and Department of Defense health care, the Nelson-Hatch-Casey amendment would be permanent law rather than an appropriations rider, subject to annual debate and approval. Any funding ban subject to annual approval will be in jeopardy in the future. Even if there are the votes to maintain the Hyde language, procedural tactics and veto threats could be employed and make it impossible to retain an annual ban.

Secondly, the Hyde amendment prohibits funding for health benefits coverage that includes coverage of abortion. This requirement ensures that the Federal Government does not encourage abortion by providing access to it. When the government subsidizes a plan, it is helping to make all of the covered services available. Federal premium subsidies authorized and appropriated in H.R. 3590 are not subject to annual appropriations and they are, therefore, not subject to the Hyde language. Directly opposite of the Hyde language, the Reid-Capps explicitly allows federal subsidies to pay for plans that cover abortion by applying an ac-

counting scheme. Under the accounting scheme, the government is permitted to subsidize abortion coverage provided that funds used to reimburse for abortions are labeled "private" funds. This is an end run around the Hyde restriction on funding for plans that cover abortion.

Furthermore, under the accounting scheme, premium holders will be forced to pay at least \$12 per year as an abortion surcharge to be used to pay for abortions. The Nelson-Casey-Hatch amendment would ensure that no funds under H.R. 3590 will subsidize plans that cover abortion. However, it does nothing to prohibit individuals from purchasing separate abortion coverage or from purchasing plans that cover abortion without a Federal subsidy.

Another issue I want to raise is the impact the Nelson-Hatch-Casey amendment would have on coverage of elective abortions by private health plans. I heard some of my colleagues say that our amendment would prohibit women from purchasing health plans with abortion coverage, even if they spend their own money. I understand there is a Politifact story with the headline "Lowey Says Stupak Amendment Restricts Abortion Coverage, Even for Those Who Pay for Their Own Plan."

That is simply not true. Our amendment would not prohibit the ability of women to obtain elective abortions as long as they use their own money to purchase these policies and not the money of the taxpayers of America, directly or indirectly. Again, our opponents will argue that it does, but if they take the time to read our amendment, they will note on page 3, line 6, that it ensures there is an option to purchase separate supplemental coverage or a plan with coverage for elective abortions. In fact, let me read it to my colleagues so we are all clear on what the language actually says. I am going to read it because I am tired of hearing some of the misrepresentations made on the floor by, I am sure, well-meaning people who are very poorly informed on this amendment. It is easy for me to see why they are poorly informed when I look at this itty-bitty bill.

My gosh, no matter how bright you are, who could know everything in this itty-bitty bill that will break the desk, if I drop it on it.

I am sorry. I scared the distinguished Senator from Iowa with this itty-bitty bill. I should have dropped it a little bit softly. I apologize.

Let me tell you what it actually says.

(2) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall be construed as prohibiting any non-Federal entity (including an individual or a State or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act; and

(B) such coverage or plan is not purchased using—

(i) individual premium payments required for a qualified health plan offered through the Exchange towards which a credit is applied under section 36B of the Internal Revenue Code of 1986; or

(ii) other non-Federal funds required to receive a Federal payment, including a State's or locality's contribution of Medicaid matching funds.

Under the Nelson-Hatch-Casey amendment, women are allowed to purchase separate elective abortion coverage with their own money. I wish they would not, but we allow it. Anybody who says otherwise is misrepresenting what this amendment does. I am sure they are not intentionally misrepresenting but nevertheless misrepresenting. So have fair warning.

It is also true that our amendment allows women to purchase a health plan that includes coverage of elective abortions in addition to the supplemental abortion policy as long as they pay for it with their own money. So when those who oppose our amendment say a woman would never want to purchase abortion coverage as a separate rider, they are truly misunderstanding that our language also permits women to purchase an identical exchange plan that includes coverage of elective abortions, in addition to other health benefits. To be clear, under our amendment, a woman may purchase with her own funds either a supplemental policy that covers elective abortions or an entire health plan that includes the coverage of elective abortions.

Today, Federal funds may not pay for elective abortions or plans that cover elective abortions. This is the fundamental component of the Hyde language. And to be clear, the Nelson-Hatch-Casey language does not prevent people purchasing their own private plans that include elective abortion coverage with private dollars.

In addition, our amendment explicitly states that these types of policies may be offered. In other words, our amendment does not restrict these policies from being offered. The only caveat is that they may not be purchased with Federal subsidies. We want to make that clear, and the Reid-Capps language does not.

Let me read that section of the Nelson-Hatch-Casey amendment for my colleagues. It may be found on page 4, line 3, of the Nelson-Hatch-Casey amendment.

(3) Option To Offer Supplemental Coverage Or Plan.—

Now get this:

Nothing in this subsection shall restrict any non-Federal health insurance issuer offering a qualified health plan from offering separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act;

(B) administrative costs and all services offered through such supplemental coverage

or plan are paid for using only premiums collected for such coverage or plan; and

(C) any such non-Federal health insurance issuer that offers a qualified health plan through the Exchange that includes coverage for abortions for which funding is prohibited under this subsection also offers a qualified health plan through the Exchange that is identical in every respect except that it does not cover abortions for which funding is prohibited under this subsection.

Our amendment has the support of the U.S. Conference of Catholic Bishops, the National Right to Life Committee, the Family Research Council, the Ethics & Religious Liberty Commission of the Southern Baptist Convention, Concerned Women for America, the National Association of Evangelicals, and Americans United for Life Action.

Polls across the country indicate a majority of Americans do not want their tax dollars paying for elective abortions. According to a CNN/Opinion Research Corporation survey, 6 in 10 Americans favor a ban on the use of Federal funds for abortion. Anybody who understands that figure knows there are pro-choice people who also favor a ban on the use of Federal funds for abortion.

It also indicates that the public may also favor legislation that would prevent many women from getting their health insurance plan to cover the cost of an abortion, even if no Federal funds are involved. This poll indicates that 61 percent of the public opposes the use of public money for abortions for women who cannot afford the procedure, with 37 percent in favor of allowing the use of Federal funds.

So my question to my fellow Senators is the following: When is this Congress going to start listening to the American people, people on both sides of this issue, who do not feel that taxpayers ought to be saddled with paying for abortion through their tax dollars, or in any other way, for that matter?

I urge my colleagues to support the Nelson-Hatch-Casey amendment. Do the right thing and support our amendment, which truly protects the sanctity of life and provides conscience protections to health care providers who do not want to perform abortions. That is an important aspect of this issue, and I have waited until the last minute to say something about that issue. Why should people of conscience be forced to participate in any aspect of elective abortions? They should not. People who have deep feelings of conscience should not be forced—that includes nurses, doctors, health care providers, hospitals—they should not be forced to do this, just because of the radicalness of some people who exist in our society today, and some think the radicalness of some in this body and in the other body. It is radical to expect the American taxpayers to pay for elective abortions, especially when such a high percentage—up to 68 percent, according to some polls, and I think even higher—do not want to have Federal dollars used for this purpose.

I appreciate my colleagues. I appreciate what my colleagues stand for. But this is very important stuff.

I ask unanimous consent that a number of constituent letters be printed in the RECORD.

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

#### CONSTITUENT LETTERS

Senator HATCH: I am absolutely and adamantly opposed to having any of my tax dollars go to fund abortion directly or indirectly. I urge you in the strongest possible terms to vote against any motion to have the Senate consider any bill that does not include specific language like the Stupak Amendment.

Please let me know how you vote on the upcoming motion to proceed to consider any healthcare legislation.

Thank you.

Senator HATCH: I am extremely concerned that the majority of members of all the congressional committees that have considered healthcare legislation have refused to specifically include language that would prohibit allowing any of my tax dollars from directly or indirectly funding abortions.

I am absolutely opposed to being forced to fund abortions in any way with my tax dollars, and I urge you not to support any healthcare bill that does not specifically prevent this. I consider abortion to be the taking of innocent life and a fundamental moral issue. I do not want to be forced to support it in any way. . . .

Thank you.

Senator HATCH: During floor debate on the health care reform bill, please support an amendment to incorporate longstanding policies against abortion funding and in favor of conscience rights. If these serious concerns are not addressed, the final bill should be opposed.

Genuine health care reform should protect the life and dignity of all people from the moment of conception until natural death.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from Nebraska be allowed to speak for up to 10 minutes.

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

The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, I rise to discuss the bipartisan amendment which I have proposed with Senator HATCH, the Presiding Officer, and others. As my good friend and colleague from Utah has so eloquently explained, our amendment mirrors the language offered by Representative STUPAK that was accepted into the House health care bill. Our view is that it should become part of the Senate health care bill we are debating as well.

It is a fact that the issue of abortion stirs very strong emotions involving strongly held principles all across America, from those who support the procedure and those who do not. We are hearing that passion at times here on the Senate floor.

But we are not here to debate for or against abortion. This is a debate about taxpayer money. It is a debate

about whether it is appropriate for public funds to, for the first time in more than three decades, cover elective abortions. In my opinion, most Americans and most of the people in my State would say no.

As it is currently written, though, the Senate health care bill enables taxpayer dollars, directly and indirectly, to pay for insurance plans that cover abortion. We should not open the door to do so. As I said yesterday, when we offered the amendment, some suggested the Stupak language imposes new restrictions on abortion. But that is not the case. We are seeking to apply the same standards to the Senate health care bill that already exist for many Federal health programs.

But the bill does set a new standard. It is a standard in favor of public funding of abortion. Our amendment does not limit the procedure, nor prevent people from buying insurance that covers abortion with their own money. It only ensures that when taxpayer dollars are involved, people are not required to pay for other people's abortions.

Some have claimed that the amendment restricts abortion coverage even for those who pay for their own plan. That is not true, according to [politfact.com](http://politfact.com), a prize-winning, fact-checking Web site, which looked at similar claims by a House Member during House debate on the Stupak amendment. PolitFact found, and I quote:

First, she suggests the amendment applies to everyone in the private insurance market when it just applies to those in the health care exchange. Second, her statement that the restrictions would affect women "even when they would pay premiums with their own money" is incorrect. In fact, women on the exchange who pay the premiums with their own money will be able to get abortion coverage. So we find her statement false.

The Nelson-Hatch-Casey amendment only incorporates the longstanding rules of the Hyde amendment, which Congress approved in 1976, to ensure that no Federal funds are used to pay for abortion in the legislation.

This standard now applies to Federal health programs covering such wide and broad groups as veterans, Federal employees, Native Americans, active-duty servicemembers, and others—all of whom are covered under some form of a Federal health program.

Thus, this standard applies to individuals participating in the Children's Health Insurance Program, Medicare, Medicaid, Indian Health Services, veterans health, and military health care programs.

I wish to emphasize another point. All current Federal health programs disallow the use of Federal funds to help pay for health plans that include abortion. Our amendment only continues that established Federal policy. Some have said the Hyde amendment already is in effect in this bill. But that is not the case at all. The bill says the Secretary of Health and Human Services may allow elective abortion

coverage in the Community Health Insurance Option—the public option—if the Secretary believes there is sufficient segregation of funds to ensure Federal tax credits are not used to purchase that portion of the coverage.

The bill would also require that at least one insurance plan that covers abortion and one that does not cover abortion be offered on every State insurance exchange.

Federal legislation establishing a public option that provides abortion coverage and Federal legislation allowing States to opt out of the public option that provides abortion coverage eases—let me repeat the word “eases”—the standards established by the Hyde amendment.

The claim that the segregation of funds accomplishes the Hyde intent falls short. Segregation of funds is an accounting gimmick. The reality is, taxpayer-supported Federal dollars would help buy insurance coverage that includes covering abortion.

I wish to offer some other points about the effect of the Nelson-Hatch-Casey amendment.

Under the amendment, no funds authorized or appropriated by the bill could be used for abortions or for benefits packages that include abortion. The amendment would prohibit the use of the affordability tax credits to purchase a health insurance policy that covers abortion. It would also prohibit Federal funding for abortion under the Community Health Insurance Option.

In addition, the amendment makes exceptions in the cases of rape or incest or in cases of danger to the mother's life.

In addition, the amendment allows an individual to use their own private funds to purchase separate supplemental insurance coverage for abortions, perhaps even what is called a rider to an existing plan.

The amendment allows an individual whose private health care coverage is not subsidized by the Federal Government to purchase or be covered by a plan that includes elective abortions, paid for with that individual's own premium dollars.

Under the amendment, a private insurer participating in the exchange can offer a plan that includes elective abortion coverage to nonsubsidized individuals on the exchange, as long as they also offer the same plan without elective abortion coverage to those who receive Federal subsidies.

On another point, under Federal law, States are allowed to set their own policies concerning abortion. Many States oppose the use of public funds for abortion. Many States have also passed laws that regulate abortion by requiring informed consent and waiting periods, requiring parental involvement in cases where minors seek abortions, and protecting the rights of health care providers who refuse, as a matter of conscience, to assist in abortion.

But perhaps most importantly, there is no Federal law, nor is there any

State law, that requires a private health plan to include abortion coverage. But the bill before us, as written, does.

As I have said, the current health care bill we are debating should not be used to open a new avenue for public funding of abortion. We should preserve the current policies, which have stood the test of time, which are supported by most Nebraskans and most Americans. The Senate bill, as proposed, goes against that majority public opinion. I think most Americans would prefer that this health care bill remain neutral on abortion, not chart a new course providing public funds for the procedure. Public opinion suggests so. So does the fact that over the last 30-plus years Congress has passed new Federal laws that have not broken with precedent.

Finally, as President Obama has said, this is a health care reform bill. It is not an abortion bill. So it is time to simply extend the longstanding standard disallowing public funding of abortion to new proposed Federal legislation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield to the Senator from California. At least indirectly it is our understanding that Senator REID will soon come to the floor to speak.

Mrs. FEINSTEIN. As soon as he comes in, I would be happy to yield.

Mr. BAUCUS. That would be my request.

Mrs. FEINSTEIN. Thank you. I appreciate that.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. Mr. President, simply put, I believe this amendment would be a harsh and unnecessary step back in health coverage for American women.

What this amendment would do, as I read it, is to prohibit any health insurance plan that accepts a single government subsidy or dollar from providing coverage for any abortion, no matter how necessary that procedure might be for a woman's health, even if she pays for the coverage herself.

The proponents of this amendment say their sole aim is to block government funds from being used to cover abortion, but the underlying bill already does that. In the bill before us, health plans that opt to cover abortion services—in cases other than rape, incest, or when the life of the mother is at stake—must segregate the premium dollars they receive to ensure that only private dollars and not government money is used. They argue that segregating funds means nothing—you heard that—and that money is fungible. However, this method of separating funds for separate uses is used in many other areas, and there is ample precedent for the provision.

For example, charitable choice programs allow agencies that promote re-

ligion to receive Federal funds as long as these funds are segregated from religious activities. We all know that. We see it in program after program. If these organizations can successfully segregate their sources of funding, surely health insurance plans can do the same. Additionally, the Secretary of Health and Human Services must certify that the plan does not use any Federal funding for abortion coverage based on accounting standards created by the GAO.

This amendment would place an unprecedented restriction on a woman's right to use her own money to purchase health care coverage that would cover abortions. Let me give my colleagues one example. Recently, my staff met with a bright, young, married attorney who works for the Federal Government. She and her husband desperately wanted to start a family and were overjoyed to learn she was pregnant. Subsequently she learned the baby she was carrying had anencephaly, a birth defect whereby the majority of the brain does not develop. She was told the baby could not survive outside of the womb. She ended the pregnancy but received a bill of nearly \$9,000. Because she is employed by the Federal Government, her insurance policy would not cover the procedure. Her physician argued that continuing the pregnancy could have resulted in “dysfunctional labor and postpartum hemorrhage, which can increase the risk for the mother.” The physician also warned that the complications could be “life threatening.”

However, OMB found that this circumstance did not meet the narrow exception in which a woman's life, not her health, is in danger. The patient was told: “The fetal anomaly presented no medical danger to you,” despite the admonitions of her physician. The best she could do was to negotiate down the cost to \$5,000.

Now, this story, without question, is tragic. A very much-wanted pregnancy could not be continued and, on top of this loss, the family was left with a substantial unpaid medical bill. Health insurance is designed to protect patients from incurring catastrophic bills following a catastrophic medical event. But if this amendment passes, insured women would lose any coverage included in the underlying bill, even if she pays for it herself. Why would this body want to do that? I can't support that.

A woman's pregnancy may also exacerbate a health condition that was previously under control, or a woman may receive a new diagnosis in the middle of her pregnancy. It happens. If this amendment passes, women in these circumstances would also learn that their insurance does not cover an abortion. In some cases, it may be unclear whether the woman's health problem meets the strict definition of life endangerment.

The National Abortion Federation has compiled calls they receive on

their hotline which are available to women who need assistance obtaining abortion care. Let me give you a few examples.

Molly was having kidney problems and was in a great deal of pain. She couldn't go to work. She couldn't provide for her two children. When she became pregnant, she made the decision to terminate the pregnancy in order to have her kidney removed to begin her recovery. She knew carrying the pregnancy would create additional health problems and would leave her unable to provide for her family.

Jamie already had severe health problems when she learned she was pregnant. She was a severe diabetic and her low blood sugar levels caused her to suffer from seizures. She was unable to continue her pregnancy but had difficulty affording the procedure.

Another was suffering from a serious liver illness when she became pregnant. Doctors were unsure of the cause, but she was in a great deal of pain. She already had two children. She could not care for them because of this pain. The tests and medications she needed to address her medical condition were incompatible with pregnancy.

None of these women experienced immediate threats to their lives, so under this amendment their circumstances would not meet the narrow exceptions permitted for abortion coverage.

This is a problem. How can one say we are going to provide insurance, but we don't like one aspect of it. We don't want the government to pay for it. OK, OK. But the woman herself can't pay for it. That is the extra step that this legislation takes.

To this day, it is still legal to have an abortion. Women in this situation don't buy insurance for abortion, but they buy a policy that may cover them, married women, should something happen in a pregnancy in the third trimester. If they find a baby is without a brain, she can have an abortion, and it is covered.

One of the problems with this whole debate is everybody sees something through their own lens. They don't see the grief and trouble and morbidity that is out there and the circumstances that drive a woman to decide—married—she has to terminate her pregnancy for very good medical reasons. Nobody considers that. This is all ideologic, and it really, deeply bothers me.

So I can only tell my colleagues I very much hope this amendment goes down.

Thank you very much, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, I would like to summarize the reasons for and the intent of the amendment that Senator HATCH and the Presiding Officer and I, together with others, have proposed to the health care bill.

First of all, I should say the examples our very good friend from Cali-

fornia has outlined would not have been covered under the Federal Employees Health Benefits Plan either because the Federal Employees Health Benefits Plan does not provide abortion coverage for such circumstances.

Our amendment mirrors the language that has been offered by Representative STUPAK that was adopted into the House health care bill, and we believe it should be applied to the Senate bill as well. As I said earlier, the issue of abortion certainly prompts strong opinions, fierce passions, and deep-seated principles for millions and millions of Americans, those who support the procedure and those who don't. But our amendment does not take sides on abortion. It is about the use of taxpayer money.

The question before us is whether public funds, for the first time in more than three decades, should cover elective abortions. Numerous public opinion polls have shown that most Americans, including a number who support abortion, do not support public funds paying for abortion. But the Senate bill we are debating allows taxpayer dollars, directly and indirectly, to pay for insurance plans to cover abortion. That is out of step with the majority of Nebraskans and of all Americans.

Our amendment does not impose new restrictions on women despite what some have claimed, and I respect but strongly disagree with them. We are seeking to just apply the same standards to the Senate health care bill that already exist for every Federal health program.

Our amendment does not add a new restriction, but the bill does add a new relaxation of a Federal standard that has worked well for more than 30 years. Under our amendment, abortion isn't limited, nor would people be prevented from buying insurance on the private market covering abortion with their own money.

Our amendment only ensures that where taxpayer money enters the picture, people are not required to pay for people's abortions.

The Nelson-Hatch-Casey amendment incorporates the longstanding standard established by the Hyde amendment which Congress approved in 1976. Today it applies to every Federal health program. That includes plans that cover veterans, Federal employees, including Members of Congress, Native Americans, Active-Duty servicemembers, and a whole host of others.

Some people have called our amendment radical. Nothing could be further from the truth. It is reasonable. It is rational because it follows established Federal law. It is right. Taxpayers shouldn't be required to pay for people's abortions. It is just that simple.

Thank you, Mr. President. I yield the floor, and I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. KAUFMAN). Without objection, it is so ordered.

Mr. REID. Mr. President, there were 45,000 funerals in America this year. These funerals, 45,000 in number, stood out from all the rest. Why? They were tearful, as all funerals are. They filled loved ones with sorrow and grief, as many of us know firsthand. But these 45,000 funerals were avoidable. That is why they were more tragic than most, because 45,000 times this year—nearly 900 times a week, more than 120 times each day, about every 10 minutes in America, every day, without end—someone dies as a direct result of not having health insurance.

That is a sickening number. You would have to be heartless not to be horrified. It doesn't even include those who did have health insurance but died because it was not enough to meet their most basic needs. That is what this is all about.

But it is not even just about death. How many citizens in each of our States are bankrupt and broke because of a broken health care system? How many have to choose between their mother's chemotherapy and their daughter's college tuition? How many have to work two or three jobs to provide for a family they never have time to see, all because of an accident they had or an illness they acquired that some insurance big shot calls a pre-existing condition.

So many of these tragedies could be prevented. If our Nation truly values the sanctity of life, as I believe it does, we will do everything we can to prevent them. That is why we are pushing so hard to make it possible for every American to afford good health. That is why we cannot take no for an answer, and that is why we will not let the American people down.

That value is also evident in the amendment before us. As some know, for many years—nearly 28 years as a Member of the House of Representatives, of the Senate, and as majority leader—I have consistently cast my vote against abortion.

To me, it is not about partisanship of any kind or political points or even polling data. To me, it is a matter of conscience.

I might not be the loudest on this topic, but that doesn't make my beliefs any less strong. I might oppose abortion, but that does not mean I am opposed to finding common ground for the benefit of the greater good. We can find common ground.

My belief in the sanctity of life is why I have repeatedly voted against using taxpayer money for abortion. It is why I have repeatedly voted against covering abortions in Federal employees health insurance plans and repeatedly voted against allowing Federal facilities to be used for abortions.

But I recognize abortion is an emotional issue. Many Senators in this

body disagree, as many citizens in the country disagree, on the issue. But divisive issues don't have to divide us. There is value in finding common ground.

Among this institution's immortals is Senator Henry Clay, who worked under the premise that, as he said:

All legislation is founded upon the principle of mutual concession.

It is in that spirit that I have been able to work with my colleagues to my left and to my right—Congressmen and Senators who are pro-life, such as I am, and those who are pro-choice. One of the ways I have done this is by trying to reduce the rate and number of unintended pregnancies.

Our great country leads the world in many ways. But this area is not one in which we take much pride. The United States has one of the highest rates of unintended pregnancies among all industrialized nations, and that is an understatement. Half of all pregnancies in America—every other one—is unintended. Of those, more than half result in abortions.

I have worked to stop this problem before it starts. In 1997, Senator Olympia Snowe and I started the first of many efforts to improve access to contraception. We said health plans should treat prescription contraception the same way it treats other prescription medications. We even passed a law that ensures that Federal employees have access to contraception. This proves what is possible when Senators have different backgrounds, both of good faith, work with each other rather than against each other.

In this case, a pro-life Democrat and a pro-choice Republican followed common sense and found common ground. I have always been appreciative of Senator SNOWE for her cooperation and her courage. I continue, to this day, to be grateful.

Let's not forget that the historic bill before this body will continue those efforts. By making sure that all Americans can get good health care, we will reduce the number of unintended pregnancies at the root of this issue. That is a goal both Democrats and Republicans can agree is worthwhile.

Let's talk about current law and this bill. In that and many other respects, this bill is a good, strong, and historic one. It is a bill that will affect the lives of every single American, and it will do so for the better. It will—as you have heard me say many times—save lives, save money, and save Medicare.

But you have also heard me say this bill deserves to go through the legislative process. That process includes amendments. It warrants additions, subtractions, and modifications, as the Senate sees fit. This is an appropriate process, one that has served this body well for more than two centuries.

The amendment before us today, offered by Senator NELSON of Nebraska, would make dramatic changes in current law in America. It is worth examining what that law says, how this bill

would treat it and what this amendment would require in addition and then evaluating whether it improves the overall effort.

As current law dictates, not a single taxpayer dollar—not one—can be used to pay for an abortion. There are very few—but very serious—exceptions to this rule: Those are explicitly limited to cases in which the life of the mother is in danger and when the pregnancy is the result of rape or incest.

This law is called the Hyde amendment. It has been on the books since the late Republican Congressman Henry Hyde wrote it in 1976. I have great respect for Henry Hyde, and I recall with fondness how this Illinois Republican Congressman came to Nevada and campaigned for me. We worked together at a time when a Republican could campaign for a Democrat and vice versa and not fear retribution and condemnation from his own party.

When we drafted the health reform bill now under consideration, we worked hard to come up with a compromise between pro-life and pro-choice Senators. On one side, there are some Senators who don't believe abortion should be legal, let alone mentioned in any health plan. On the other side, there are Senators who don't want a woman's access to legal abortion to depend on which health plan she could afford, and they wanted that reflected in this bill.

So legislating in pursuit of mutual concession, as Senator Clay advised, we struck a compromise. It is a compromise that recognizes people of good faith can have different beliefs, and instead of trying to settle the sensitive question of abortion rights in this bill, we found a fair middle ground.

That compromise is, we maintain current law. We are faithful to the Hyde amendment, which has been in place now for 33 years. Let me be clear. As our bill currently reads, no insurance plans in the new marketplace we create—whether private or public—would be allowed to use taxpayer money for abortion, beyond the limits of existing law.

But we don't stop there. The bill takes special care to keep public and private dollars separate to make sure that happens. This isn't a new concept. It is worth noting this practice of segregating money is consistent with other existing rules that make sure the public doesn't pay for things it shouldn't. It is consistent with the existing Medicaid practice that gives States the option of covering abortion also at their expense. It mirrors practices already in place to separate church and State by ensuring money the Federal Government gives religious organizations is not used for religious practices. So we are not reinventing the wheel.

Just as current law demands, the bill respects the conscience of both individual health care providers and health care facilities. And once again, it goes further. Our bill not only safeguards a

long list of Federal laws regarding conscience protections and refusal rights, it even outlaws discrimination against those health care providers and facilities with moral and religious objections to abortion. That means if a doctor does not believe it is right to perform an abortion, he or she can say no, no questions asked. Health care facilities such as Catholic hospitals, which are the largest nongovernment, non-profit health care providers in the country, would continue to have the same right to refuse to perform abortions.

Under our bill, at least one plan that does not cover abortion services will have to be offered in each exchange so no one will be forced to enroll in a plan that covers abortion services. This is an improvement since the current marketplace does not provide a similar guarantee.

It is clear that the current bill does not expand or restrict anyone's access to abortion, period. It does not force any health plans to cover abortion or prohibit them from doing so, period. Why? Because this bill is about access to health care, not access to abortions.

I have great respect for Senator BEN NELSON. His integrity and independence reflect on the Nebraskans he represents. His strong beliefs are rooted in his strong values. But he shows, better than most, that one can be steadfast without being stubborn. Senator NELSON has always been a gentleman whose consideration is the true portrait of how a Senator should conduct oneself.

I mentioned that our underlying bill leaves current law where it is. This amendment, however, does not. It goes further than the standard that has guided this country for 33 years. It would place limits not only on taxpayer money, which I support, but also on private money. Again, current law already forbids Federal funds from paying for abortions, and our bill does not weaken that rule one bit. I believe current law is sufficient, and I do not believe we need to go further. Specifically, I do not believe the Senate needs to go as far as this amendment would take us. No one should use the health care bill to expand or restrict abortion, and no one should use the issue of abortion to rob millions of the opportunity to get good health care.

This is not the right place for this debate. We have to get on with the larger issue at hand. We have to keep moving toward the finish line and cannot be distracted by detours or derailed by diversions.

Our health reform bill now before this body respects life. I started by saying I believe in the sanctity of life. But my strong belief is that value does not end when a child is born; it continues throughout the lifetime of every person.

With this bill, nearly every American will be able to afford the care they need to stay healthy or care for a loved one. It respects life.

Those who today have nowhere to turn will soon have security against what President Harry Truman called “the economic effects of sickness.” It respects life.

Those who suffer from disease, from injury, or from disability will no longer be told by claims adjustors they never met that they are on their own. It respects life.

It will help seniors afford every prescription drug they need so they do not have to decide which pills to skip and which pills to split. It respects life.

It will stop terrible illnesses before they start and stop Americans from dying of diseases we know how to treat. It respects life.

We will stop terrible abuses, such as insurance companies looking at earnings reports instead of your doctor’s report and charging rates that make the health we want a luxury. It respects life.

We will ensure the most vulnerable and the least prosperous among us can afford to go to a doctor when they are sick or hurt, not to the emergency room where the rest of us pick up the bill. It respects life.

This bill recognizes that health care is a human right. This bill respects life.

The issue in this amendment is not the only so-called moral issue in this debate. The ability of all Americans to afford and get the access to care they need to stay healthy is also a question of morality.

The reason I oppose abortion and the reason I support the historic bill is the same: I respect the sanctity of life.

This is a health care bill. It is not an abortion bill. We cannot afford to miss the big picture. It is bigger than any one issue. Neither this amendment nor any other should be something that overshadows the entire bill or overwhelms the entire process.

Throughout my entire public career, I voted my conscience on the subject of abortion. As I said, that decision is based on something personal with me. My vote today will also honor another principle I believe to my very core and that I will believe until my very last day on Earth: We must make it possible for every American to afford a healthy life.

I believe the compromise in our current bill and the current bill itself fully fulfill both of these moral imperatives. And I believe when we are given the trust of our neighbors, friends, relatives, the privilege to lead the opportunity to improve others’ lives, we cannot turn our backs. We cannot turn our backs on the tens of millions of Americans who have no health insurance at all—none—not thousands, not hundreds, not millions but tens of millions. We cannot turn our backs on the many who do but live one accident, one illness, or one pink slip away from losing that insurance they have.

One of the most cherished charters this Nation has, drafted by one of our most beloved leaders, declared life to be the first among several of our abso-

lute rights. Jefferson put it even before liberty, even before the pursuit of happiness—life.

If we still truly value life in America—and I believe we do—if we still truly value the life of every American, we cannot turn our backs on the 14,000 of us who lose health coverage every single day of every week of every month of every year in this country—no weekends off, no vacations. How many of the thousands of men, women, and children who today will be kicked out in the cold will next year become one of the tens of thousands who die because of it? If we value the sanctity of life, as I know we do, and fix what is broken, as I know we must, we will not have to find out.

I believe in this bill and what it will do for our country for generations to come, what it will do for our constituents, my children, my grandchildren, and their children and their grandchildren. I will not support efforts to undermine this historic legislation.

Mrs. BOXER. Mr. President, I ask unanimous consent that the Senate proceed to vote in relation to the Nelson-Hatch amendment No. 2962; that regardless of the outcome of the vote with respect to that amendment, there be 2 minutes of debate prior to a vote in relation to the McCain motion to commit, equally divided and controlled in the usual form; that upon the use or yielding back of that time, the Senate proceed to vote in relation to the McCain motion to commit; the McCain motion be subject to an affirmative 60-vote threshold; that if the motion achieves that threshold, then it be agreed to and the motion to reconsider be laid upon the table; that if it does not achieve that threshold, then it be withdrawn; and that no amendment be in order to the motion.

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

Mrs. BOXER. Mr. President, I move to table the Nelson amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The question is on agreeing to the motion. The clerk will call the roll.

The legislative clerk called the roll. Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 45, as follows:

[Rollcall Vote No. 369 Leg.]

YEAS—54

Akaka	Collins	Kerry
Baucus	Dodd	Kirk
Begich	Durbin	Klobuchar
Bennet	Feingold	Kohl
Bingaman	Feinstein	Landrieu
Boxer	Franken	Lautenberg
Brown	Gillibrand	Leahy
Burr	Hagan	Levin
Cantwell	Harkin	Lieberman
Cardin	Inouye	Lincoln
Carper	Johnson	McCaskill

Menendez	Rockefeller	Tester
Merkley	Sanders	Udall (CO)
Mikulski	Schumer	Udall (NM)
Murray	Shaheen	Warner
Nelson (FL)	Snowe	Webb
Reed	Specter	Whitehouse
Reid	Stabenow	Wyden

NAYS—45

Alexander	Crapo	LeMieux
Barrasso	DeMint	Lugar
Bayh	Dorgan	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Nelson (NE)
Bunning	Grassley	Pryor
Burr	Gregg	Risch
Casey	Hatch	Roberts
Chambliss	Hutchison	Sessions
Coburn	Inhofe	Shelby
Cochran	Isakson	Thune
Conrad	Johanns	Vitter
Corker	Kaufman	Voivovich
Cornyn	Kyl	Wicker

NOT VOTING—1

Byrd

The motion was agreed to. Mrs. BOXER. I move to reconsider the vote.

Mrs. FEINSTEIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, there will be 2 minutes of debate equally divided prior to a vote in relation to the motion to commit offered by the Senator from Arizona.

Who yields time? The Senator from Montana.

Mr. BAUCUS. Mr. President, the McCain motion to commit on Medicare Advantage would keep overpayments in the Medicare Advantage program, even though the Medicare Payment Advisory Commission recommends that they be eliminated.

The McCain motion to commit is a tax on all seniors. It would maintain the overpayments to private insurers and require beneficiaries to pay higher Part B premiums. The average couple pays \$90 per year just so insurers can reap greater profits under Medicare.

The McCain amendment is a raid on the Medicare trust fund. MA overpayments take 18 months off the life of the Part A trust fund. And according to MedPAC, there is no evidence of greater quality of care. In fact, MedPAC told Congress this year that “only some” MA plans are of high quality. MedPAC finds that “only half of beneficiaries nationwide have access to a plan that Medicare rates above average on overall plan quality.”

The more than 45 million seniors with Medicare deserve better. They do not deserve to subsidize high profits of private insurers. And the more than 11 million Medicare beneficiaries who choose to enroll in private plans also deserve better. They deserve plans that coordinate care. Most plans today do not. They deserve plans that are of high quality. Many plans today do not.

If Senators want to help beneficiaries, they will vote to eliminate overpayments under Medicare Advantage. And they should vote against the McCain motion.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, this amendment is about an earmark. It is about a special deal cut for a special group of people who happen to reside in the State of Florida. I am never so presumptuous. I have lost too many votes trying to eliminate earmarks. But what I am trying to do is allow every American citizen who is enrolled in Medicare Advantage to have the same protection of their Medicare Advantage Program as the Senator from Florida has carved out in this bill. That is all it is about. It is about equality. It is about not letting one special group of people who reside in a particular State get a better deal than those who live in the rest of the country. That is all this amendment is about.

It will probably be voted down on a party-line vote. But what you have done is you have allowed a carve-out for a few hundred thousand people in the State of Florida and have disallowed the other 11 million who have Medicare Advantage from having their health care cut. That is what this is all about.

Mr. BOND. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 57, as follows:

[Rollcall Vote No. 370 Leg.]

YEAS—42

Alexander	DeMint	McCain
Barraso	Ensign	McConnell
Bennett	Enzi	Murkowski
Bond	Graham	Nelson (NE)
Brownback	Grassley	Risch
Bunning	Gregg	Roberts
Burr	Hatch	Sessions
Chambliss	Hutchison	Shelby
Coburn	Inhofe	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Webb
Crapo	Lugar	Wicker

NAYS—57

Akaka	Feinstein	McCaskill
Baucus	Franken	Menendez
Bayh	Gillibrand	Merkley
Begich	Hagan	Mikulski
Bennet	Harkin	Murray
Bingaman	Inouye	Nelson (FL)
Boxer	Johnson	Pryor
Brown	Kaufman	Reed
Burr	Kerry	Reid
Cantwell	Kirk	Rockefeller
Cardin	Klobuchar	Sanders
Carper	Kohl	Schumer
Casey	Landrieu	Shaheen
Conrad	Lautenberg	Specter
Dodd	Leahy	Stabenow
Dorgan	Levin	
Durbin	Lieberman	
Feingold	Lincoln	

Tester	Udall (NM)	Whitehouse
Udall (CO)	Warner	Wyden

NOT VOTING—1

Byrd

The PRESIDING OFFICER. On this vote, the yeas are 42, the nays are 57. Under the previous order requiring 60 votes for adoption of the motion, the motion is withdrawn.

Mrs. HUTCHISON addressed the Chair.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Texas.

Mr. DORGAN. Madam President, will the Senator from Texas yield for a unanimous consent request?

Mrs. HUTCHISON. I will.

Mr. DORGAN. Madam President, I ask unanimous consent that following the presentation by the Senator from Texas that I be recognized to offer an amendment, and following that Senator CRAPO be recognized to offer an amendment, and Senator CRAPO, I believe, wishes to speak 2 or 3 minutes, and following that then I would be recognized as well for a presentation on the amendment I have offered, and following my presentation, the Senator from Minnesota, Ms. KLOBUCHAR, would be recognized, and Senator KAUFMAN would be recognized as part of the colloquy with Senator KLOBUCHAR.

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

The Senator from Texas.

Mrs. HUTCHISON. Madam President, we have spent the last few days highlighting how this health care reform bill is paid for by cutting benefits to seniors, jeopardizing their access to care. Almost \$500 billion will be cut from the Medicare Program.

But this bill also imposes  $\frac{1}{2}$  trillion in new taxes. These are taxes that hit every American and virtually every health care business or related business in the country.

During an economic downturn, this approach is counterintuitive. These taxes will discourage investment and hiring. We are in one of the worst economic downturns in the history of our country. We do not need to tell anybody that. We are all feeling it. We know people who are suffering right now.

I look at what has been done in the past when we have had economic downturns, and I look at President Kennedy, President Reagan, President Bush. They lowered taxes. What happened? The economy was spurred. Lower taxes have proven to spur the economy. Yet in this bill we see  $\frac{1}{2}$  trillion in new taxes on families and small businesses.

Let's walk through some of these taxes.

Employer taxes. Madam President, \$28 billion in new taxes is imposed on businesses that do not provide health insurance to their employees. To avoid the tax, an employer has to provide the right kind of insurance—insurance that the Federal Government approves. It is going to be a certain percentage and have certain coverage requirements. Employers who do not provide the

right kind of insurance could see a penalty as high as \$3,000 per employee.

We should be encouraging people to hire in this kind of environment. That should be job No. 1: creating jobs.

Yet imposing taxes and fines are what is in this bill, and that is not going to encourage hiring; it is going to discourage hiring. That is economics 101.

Individual taxes: There are \$8 billion in taxes for those who don't purchase insurance on their own. The tax is \$750 per person. Again, because you are insured today does not mean you will avoid the tax. You must have the right kind of insurance—insurance that the Federal Government approves and says is the right amount of insurance.

How about the taxes on high-benefit plans? There are \$149 billion in taxes on health insurance plans that the Federal Government says are too robust. These high-benefit plans—Cadillac plans some call them—would be subject to a 40-percent excise tax. To make it worse, the tax is not indexed, so it is a new AMT, a new alternative minimum tax that everyone says was not supposed to encroach on lower income people, but, in fact, it has because it is not indexed for inflation.

So here we are. In this bill, you get taxed if you don't provide enough benefits and you get taxed if you provide too many benefits. So this is beginning to sound like government-run health care to me, and I can only imagine how the unions feel because they are the ones that have these high-benefit plans and here they are under fire because they have too much coverage.

Medicare payroll tax: This is the new payroll tax that is imposed on individuals making more than \$200,000 and couples making more than \$250,000. That tax raises another \$54 billion. This additional payroll tax is a marriage penalty. It is not indexed to inflation, meaning it is another AMT in the making because today, that may sound high—\$200,000 and \$250,000—but it is a huge marriage penalty, and it could begin then to go down in numbers so that more and more people are affected.

This body voted unanimously during the budget debate—unanimously—that a point of order would be made against legislation that would impose a marriage penalty in the budget. So we have voted unanimously that a budget point of order would stand if there is a marriage penalty in the budget. So now here we are a few months later, and the majority is not only retreating from the opposition to the marriage penalty, but we now have for the first time in our Tax Code—or will when this bill passes—a payroll tax marriage penalty. How on Earth can we do that?

I am going to fight this marriage penalty, and I hope the Senate will vote against this concept. It is a new precedent that could be set in other areas that would say if you are married, you are going to get fewer benefits than if you are single. That is not a precedent we ought to be setting.

Then there is the medical deduction cap. There is a change in our Tax Code that would limit the itemized deduction for medical expenses. We have always had one that said if your medical expenses go above 7.5 percent of your income, that you would be able to deduct anything above that. This bill increases that threshold to 10 percent so that if you are going to get deductions—and this is going to affect people who have catastrophic accidents, really, really high medical bills, debilitating health conditions, or very, very expensive medicine—if you go above 7.5 percent today, you would be able to deduct. But in this bill, it is going to be 10 percent of your income before the government is going to allow you to deduct these added expenses.

Then there is the drug, device, and insurance company taxes: \$60 billion in taxes assessed to insurance companies, \$22 billion to prescription drug manufacturers, and \$20 billion on medical device manufacturers. The experts have said, all of the economists have said these taxes will be paid by the public. Of course they are going to be passed on: higher premiums for every insurance policy that is already there, and higher prices for medications and medical equipment.

So medications you take for diabetes or heart disease, medications or medical devices that you need to fight cancer would all become more expensive because every one of them would have a higher cost because the company is going to pay an added fee just for producing these medicines and equipment.

So many people today are struggling with their medical bills. They are struggling to fill prescriptions. Why aren't we bringing costs down? Isn't medical cost part of the reason for reform because the costs are going up? Wasn't the point of reform to bring the costs down so more people would have affordable options for health care coverage? What happened to that? All of these taxes on individuals and businesses are going to drive prices and costs up.

In closing, the bill before us imposes \$½ trillion in new taxes at a time when unemployment is soaring and our economy is struggling. We have \$½ trillion in cuts to Medicare which is going to severely hurt our senior citizens and their access to health care, and then \$½ trillion in tax increases, taxing marriage, taxing Tylenol, taxing high-benefit plans, taxing low-benefit plans, taxes if you offer employee health care coverage, and taxes if you offer not quite enough. This is a tax-and-spend bill.

Republicans have repeatedly put forward ideas that would reform our health system, bring the costs down without burdening our employers with more taxes that would keep them from helping our economy by hiring more people; ideas that would increase competition and transparency and ensure access to affordable care.

So I hope while our colleagues are meeting to try to get their 60 votes—

which we know they are—that maybe they might consider bringing everybody into this process and listening to other ideas that would not be a government takeover of our health care system; that would not be more government mandates, more taxes, cuts from Medicare services. This is a recipe for disaster for our country, and I hope it is not too late for the Democratic majority to say: OK, let's get together and try to put together a bipartisan plan that will not hurt the quality of health care that Americans have known and expected in our country, one that will bring costs down and make health care more affordable, one that will give carrots to our employers not sticks that will switch them if they don't have the right kind of coverage or the government-approved coverage or the right percentage of coverage.

We can do better and I hope we will. Thank you, Madam President. I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

AMENDMENT NO. 2793, AS MODIFIED, TO  
AMENDMENT NO. 2786

(Purpose: to provide for the importation of prescription drugs)

Mr. DORGAN. Madam President, I call up amendment No. 2793, as modified, and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from North Dakota [Mr. DORGAN], for himself, Ms. SNOWE, Mr. GRASSLEY, Mr. MCCAIN, Ms. STABENOW, Ms. KLOBUCHAR, Mr. BROWN, Mrs. SHAHEEN, Mr. VITTER, Mr. KOHL, Mr. LEAHY, Mr. FEINGOLD, and Mr. NELSON of Florida, proposes an amendment numbered 2793 to amendment No. 2786, as modified.

Mr. DORGAN. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. DORGAN. Madam President, my understanding is that the Senator from Idaho is to be recognized next for laying down an amendment.

The PRESIDING OFFICER. The Senator from Idaho.

MOTION TO COMMIT

Mr. CRAPO. Madam President, I have a motion at the desk which I wish to call up and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Idaho [Mr. CRAPO] moves to commit the bill H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that provide that no provision of this Act shall result in an increase in Federal tax liability for individuals with adjusted gross income of less than \$200,000 and married individuals with adjusted gross income of less than \$250,000.

Mr. CRAPO. Thank you, Madam President.

As the motion which has just been read clearly states, this motion would be to commit this bill to the Finance Committee for the Finance Committee to do one simple thing, and that is to make the bill conform to President Barack Obama's pledge to the American people about health care reform and who would pay for health care reform.

In a speech he has given in a number of different places, President Obama has very clearly stated:

I can make a firm pledge . . . no family making less than \$250,000 will see their taxes increase . . . not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes. You will not see any of your taxes increase one single dime.

All this motion does is to commit this bill to the Finance Committee to have the Finance Committee assure that its provisions comply with this pledge.

Now, why would we want to do that? I think most Americans are very aware today that this bill comes at a huge price. There are \$2.5 trillion of new Federal spending, \$2.5 trillion of new Federal spending that is offset, if you will, by about \$500 billion worth of cuts in Medicare and \$493 billion worth of cuts in the first 10 years are tax increases, \$1.2 trillion of tax increases in the first real 10 years of the full implementation of the bill. There is no question but that much of the tax increase that is included in this bill to pay for this massive increase in Federal spending will come squarely from people in the United States who make less than \$250,000 as a family or less than \$200,000 as individuals.

All we need to do is to go through this bill to see that by the analysis we have made so far, it appears that at least 42 million households in America will pay a portion of this \$1.2 trillion in new taxes, people who are under these income levels to whom President Obama made the pledge.

I will have a greater opportunity tomorrow to discuss this motion in more detail. Tonight I just had a few minutes to make the introduction and to call up the motion, and we will then get into a fuller discussion on how this bill provides a heavy tax burden on the middle class of this country in direct violation of the President's pledge.

So as I conclude, I would simply say this is a very simple amendment. We can debate about whether the bill does or does not increase taxes—I think that is absolutely clear—on those in the middle class. But all the motion would do is to commit this bill to the Finance Committee to have the Finance Committee make the bill comport with the President's pledge.

I will conclude by just reading his pledge one more time. The President, in his words, said:

I can make a firm pledge . . . no family making less than \$250,000 will see their taxes increase . . . not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes. . . . you will not see any of your taxes increase one single dime.

That is what this motion accomplishes.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Madam President, the amendment I have offered with many colleagues—over 30 colleagues, Republicans and Democrats, a bipartisan legislation—deals with the issue of prescription drugs; specifically, the importation of FDA-approved drugs that the American people would be able to access for a fraction of the price they are charged in this country.

The American people are paying the highest prices in the world for brand-name prescription drugs.

It is not even close. Let me just show the first chart. I have many. I will show the first one to describe what brings me to the floor of the Senate.

Here are prices for Lipitor. There are so many people who take Lipitor that they probably ought to put it in the water supply—the most popular cholesterol-lowering drug in America, perhaps in the world. Here is what the American people pay for an equivalent quantity: \$125. The same quantity costs \$40 in Britain, \$32 in Spain, \$63 in the Netherlands, \$48 in Germany, \$53 in France, and \$33 in Canada. Once again, it is \$125 to the American consumer.

Here are the two bottles for Lipitor. It is made in Ireland by an American company and then sent around the world. This happened to go to Canada, and this went to the United States. It is the same pill, same bottle, same company, made at the same manufacturing plant, and it is FDA approved. Difference? The American consumer gets to pay three to four times higher cost. Fair? Not for me.

That is what this amendment is about. This amendment is about freedom, giving the American people the freedom in the global economy to buy the same FDA-approved drug from those countries that have an identical chain of custody as we do in this country, so an FDA-approved drug sold for a fraction of the price—why should we prevent the American people from being able to exercise and see the same savings every other consumer in the world sees?

Let me see whether anybody recognizes this. Prescription drugs are a significant part of our lives. We are bombarded with ads every single day. Let me show a demonstration of the push for consumption of prescription drugs at the highest brand-name prices in the world.

On television, Sally Field says to us—and I have seen it many mornings when I am brushing my teeth—she says this:

I always thought calcium, vitamin D, and exercise would keep my bones healthy. But I got osteoporosis anyway, so my doctor started me on once-a-month Boniva. And he told me something important: Boniva works with your body to help stop and reverse bone loss.

My test results proved I was able to stop and reverse my bone loss with Boniva. And studies show that after one year, 9 out of 10 women did, too.

I've got this one body and this one life. So I wanted to stop my bone loss. But I did more than that; I reversed it with Boniva.

Ask your doctor if Boniva is right for you.

Here is another one:

Some of us need help falling asleep. Some of us need help staying asleep. A good night's sleep doesn't have to be an on/off thing anymore.

From the makers of the most prescribed name in sleep medicine comes controlled release Ambien CR. It's the only one with two layers of sleep relief.

Ambien CR is a treatment you and your doctor can consider along with lifestyle changes and can be taken for as long as your health care provider recommends.

So ask your health care provider about Ambien CR, for a good night's sleep from start to finish.

Here is another one:

Does your restless mind keep you from sleeping? Do you lie awake exhausted? Well, maybe it's time to ask whether Lunesta is right for you.

For a limited time, you're invited to take the 7-night Lunesta challenge. Ask your doctor how to get 7 nights of Lunesta free and see if it's the sleep aid you've been looking for.

Get your coupon at Lunesta.com and ask your doctor today.

Here is another one:

They're running the men's room marathon, with lots of guys going over and over. And here's the dash to the men's room with lots of guys going urgently. Then there's a night game waking up to go.

These guys should be in a race to see their doctors. Those symptoms could be signs of BPH or enlarged prostate. Waking up to go, starting and stopping, going urgently, incomplete emptying, weak stream, going over and over, straining.

For many guys, prescription Flomax reduces urinary symptoms associated with BPH in one week. Only a doctor can tell if you have BPH and not a more serious condition like prostate cancer.

Call 1-877-FLOMAX to see if Flomax works for you and to see if you qualify for \$40 off your prescription.

For many men, Flomax can make a difference in one week.

Here is another one:

There are moments you look forward to, and you shouldn't have to miss out on them. Sometimes a bladder control problem can cause unwanted interruptions. It doesn't have to be that way. Overactive bladder is a treatable medical condition.

Enablex is a medication that can help reduce bladder leaks and accidents for a full 24 hours. Ask your doctor about Enablex.

Well, I have a couple dozen more.

Most people understand what this is because they have heard them all—things like: Go ask your doctor if the purple pill is right for you. They don't have the foggiest idea what a purple pill is for. They think that with all these scenes of trees and green grass and convertible cars and pillow clouds in the sky, if life is like that when you are on the purple pill, give me some purple pills. I mean, that is what this advertising is all about.

I don't mean to make light or fun of all of it. Prescription drugs are important in people's lives. I understand that. But you know what, you can only get a prescription drug if your doctor prescribes it and believes you need it.

These advertisements are telling people sitting at home watching a television program tonight that you need to get up and go talk to your doctor and see if you don't need some of these pills. It is trying to create consumer demand for something you can get only because a doctor believes you should have it.

Well, that is where we are now with prescription drugs in our country. A lot of people are taking prescription drugs. A lot of these drugs are miracle drugs, and they allow people to stay out of a hospital. They don't have to be in an acute-care hospital bed if they manage the disease—whether it is high blood pressure, high cholesterol—with medicine. That is good, and I understand that. But this consumer demand-driven urge for prescription drugs is pretty unbelievable. Go talk to a doctor and ask that doctor what happens every single day in the doctor's office. Somebody is coming in and saying: I wonder if I shouldn't be taking some of this medicine. I read about it or saw the advertisement about this. I wonder if I shouldn't be taking some of it. It is quite a deal.

You produce all of this demand with dramatic amounts of marketing, promotion, and advertising, and then you jack up the price and keep it up. The question is, Who can afford these prescription drugs? Who can afford them?

So that is what brings me to the floor of the Senate today saying that when the American people are charged the highest prices for brand-name drugs—and this year, it goes up close to 10 percent once again in price—at a time when we have almost no inflation, isn't that pricing prescription drugs out of the reach of too many Americans?

We are now talking about health care reform. There is nothing in any of this legislation in the House or the Senate that addresses this question of the steep and relentless price increases on prescription drugs. There is nothing in any of this legislation that does that. The question is, Shouldn't we be addressing this as well?

I talked about Lipitor. Let me show you Plavix. Do you see the U.S. price? The U.S. consumer pays the highest prices in the world.

Here is Nexium. If you want to buy that, you get to pay \$424 in the United States, and it is \$41—one-tenth the price—in England, \$36 in Spain, and \$37 in Germany. The question is this: If Nexium is an FDA-approved drug—and it is—made in plants approved by our FDA—and it is—why should an American citizen not be able to access this drug from here, from here, and from here? It is because the pharmaceutical industry doesn't want them to. They have had enough friends here to keep in place a law that prevents the American people from reimporting these drugs. That is why.

That is what this amendment is about. This amendment says: Give the American people the freedom to access

FDA-approved drugs where they are sold at a fraction of the price.

Madam President, there is a lot to talk about, and I will describe a number of circumstances that have brought us to this point.

This is the place for this amendment—not some other place; this is the place. It is about health care. We have been told over and over again that our problem is that health care is consuming too large a portion of the GDP of this country—roughly 17.3 percent, I believe. All right, part of health care—not the largest part but one of the fastest growing parts is prescription drugs. So if the issue is that health care is rising in cost relentlessly and consuming too large a portion of our GDP because we spend much more on health care than anybody else in the world by far—it is not even close—if that is the case and if one of the fastest rising areas of health care is drug costs, then why would legislation that leaves this Chamber or the House of Representatives not include something that addresses these unbelievable price increases for prescription drugs? How is it that we would allow that to happen? I don't know how we got to this point without having it in the bill, but I aim to try to put it in.

I understand, by the way, that there is tremendous pushback by the pharmaceutical industry. If I had the sweetheart deal they have, I would fight to the finish to try to keep it. I understand that.

By the way, let me just say, as I have always said and nobody hears it very much—certainly the pharmaceutical industry will never hear this—that some of the things the pharmaceutical industry does for this country are laudable. I say, good for you. They talk about the prescription drugs they produce. Good for them. A substantial portion of that comes from research we have done and paid for at the National Institutes of Health with taxpayer funds. But that doesn't matter to me. That information ought to be available to the pharmaceutical industry—and it is—so they can produce these new miracle drugs. I commend them.

My beef is not that they produce pharmaceutical drugs that help people. I am all for that. My beef is the way they price those drugs, saying to the American people: You will pay the highest prices in the world, and there is nothing you can do about it. It is their pricing policy. It is just not fair.

How many in this Chamber have visited with somebody at a town meeting someplace—I have—and they come up to you—in this case, an elderly woman who was close to 80 touched me gently on the elbow and said, “Senator DORGAN, can you help me?” She was talking about how many prescription drugs she had to take, how little money she had to pay for them, and how she always had to try to determine what her rent cost was and how much groceries she could buy to determine how much she had left to pay for prescription

drugs. How many people have said to you: Yes, I take the drugs my doctor asks me to take, but I cut them in half because I cannot afford the whole dose. We have all heard that. So the question is, Are we going to do something about it?

This is a chart that shows price increases in 2009. Enbrel, for arthritis, is up 12 percent. Singulair, for asthma, is up 12 percent. Boniva is up 18 percent. Nexium is up 7 percent.

I want to talk a bit about the issue of drug prices versus inflation. This chart shows what has happened to the price of prescription drugs, the red line, and the inflation rate in this country, the yellow line. It describes why it is urgent that we do something, why we cannot allow a health reform bill to leave this Chamber and do nothing about the issue of prescription drugs. We must at least address this question of whether the American people should not have the freedom to access these identical drugs where they are sold elsewhere for a fraction of the price.

This year, there was a 9.3-percent increase in brand-name prescription drug prices, at a time when inflation is going down. We have had deflation. That is not justifiable.

Madam President, I know we are going to have a lot of debate here in the Chamber about a lot of things. I will describe tomorrow morning, when I speak, that 40 percent of the active ingredients in U.S. prescription drugs currently come from India and China. And they are worried about somebody from Sioux Falls, SD, buying prescription drugs from Winnipeg. Are you kidding me? Again, 40 percent of the active ingredients in U.S. prescription drugs currently come from India and China. In most cases, the places those active ingredients come from have never been inspected.

I will talk about that, but I am not going to go into it tonight. I will talk about a number of issues related to drug safety of the existing drug supply and how what we have included in this legislation with respect to pedigree, batch lots and track and trace will dramatically improve the existing drug supply in our country and make certain we prevent safety problems coming from the importation of drugs.

I am going to speak about this at some length tomorrow. But I just received a letter from the head of the FDA, Margaret Hamburg, who raises some questions about the amendment. I am not going to read the letter into the RECORD. I will talk more about it tomorrow.

I must say, I am in some ways surprised by the letter and in some ways not surprised at all. Surprised, because this administration, President Obama, was a cosponsor of this legislation last year in the Senate—a cosponsor of my legislation. He was part of a bipartisan group that believed the American people ought to have this right and believed we could put together a piece of legislation that has sufficient safety

capabilities and, in fact, dramatically enhances the safety of our existing drug supply.

I am going to show tomorrow that the existing drug supply has all kinds of issues. I will show batch lots of existing drugs that have gone through strip joints, in the back room in coolers, and distributed out of strip joints. I am going to talk about that. But, first, I wish to say I was surprised to get this letter because both the President and the Chief of Staff at the White House were a cosponsor in the Senate and a leader in the House for reimportation of prescription drugs.

I called the head of the FDA yesterday afternoon about this time and said: I have heard rumors that there was a letter coming to Capitol Hill on this issue. She told me she was not aware of such a letter. Twenty-four hours later, apparently she is aware of that letter because she signed it. I am interested in where it was written, but that is another subject I will save for tomorrow as well.

We will be told, as we have been so often, that if you allow the American people to buy prescription drugs that are FDA approved from elsewhere, it will be somehow unsafe. The implication is, we are not smart enough and we are not capable enough of putting together a system that the Europeans have had together for 20 years.

In Europe, they do this routinely. For 20 years, they have had something called parallel trading. You are in Germany and want to buy a prescription drug from Spain? No problem. You are in Italy and want to buy a prescription drug from France? No problem. They have a specific parallel trading system, and it works and works well.

I am going to describe, in the words of someone who has been involved in that system for many years, that the Europeans can do, have done it, do it today with no problems at all. Are people saying they can do it, they are smart enough, they are capable enough, but we are not? Give me a break. That makes no sense to me at all. Of course, we can do this.

It is just that those who do not want to do it have decided this current “deal,” which allows the pharmaceutical industry to price as they wish in this country and make certain the American people cannot do anything to get the lesser prices in other countries, lower prices for the identical drug, it means they will price this year up 9.3 percent, just this year alone. They will do whatever they want to price those prescription drugs and too often will price them out of reach of the American people. It is not fair to me. It does not make any sense to me.

I know some will view this as just an attack on the pharmaceutical industry. It is not intended to be that. As I said, I don't have a grievance against that industry at all. The only problem I have is the way they price their product, and I think it is not fair to the American people.

We are dealing with health care, which is a big issue and an unbelievably controversial issue. This is one piece of it—not even the biggest piece—but it is an important piece.

I have a lot to say tomorrow morning, and I will take substantial time. I know there are others who want to speak tonight. I wish to say this. I have watched and listened in this Chamber now for some while. I have not spoken a lot on health care. I have been pretty distressed about some of what has been said on the floor of the Senate. I especially have been distressed with the television ads that have been running that are unbelievably dishonest with respect to the facts. The first amendment allows all that. I would be the last to suggest we ought to alter the first amendment.

This is a great country in which we live. Over the last century, for example, we have made a lot of changes, and in most every case—in most every single case—the changes have been unbelievably painful.

I think of the Presiding Officer and think of the period in which the women in this country wanted the right to vote and were taken to the Occoquan Prison and beaten. Lucy Byrne and Alice Paul, they nearly choked to death one of them; the other hung with a chain from a prison door all night long with blood running down her arms. Why? Because they wanted the right to vote. Think of the pain of that.

Now we look back and say: How could anybody have decided we are all Americans except women do not have full participation because they cannot vote? Think of that. You can go right up the line. Social Security: a Communist socialist plot. Medicare: What are you thinking about? A takeover of health care for senior citizens.

I bet there is not—I was going to say I bet there is not one. I shouldn't say that. I bet there are not more than two or three people in this Chamber, if we said: Let's get rid of Medicare, who would say: Yes, let's do that. Almost everybody believes that providing health care for senior citizens was the right thing to do.

There were no insurance companies in the fifties and early sixties that said: Here is our business strategy. Our business strategy is to go look for old people and see if we can't sell them health insurance because we think that would be a very good deal. They were not doing that. They would not even make health insurance available to a lot of old folks because they know, somewhere toward the end of their lives, they were going to need a lot of health care. One-half of the senior citizens in America had no access to health care. Think of that—lie down on your pillow at night frightened that tomorrow might be the day you have this dreaded disease and you have no coverage to see a doctor or go to a hospital. It is unbelievable.

So some people in this Chamber said: Let's do Medicare. Man, that was rad-

ical. People said: Socialist plot, government takeover. But we did it. I was not here. They did it—God bless the ones who did it—and it enriched this country, to say all those who lived their lives and built the roads and built the schools and built the communities and left a better place for us: You are not going to have to lay awake at night frightened about your health care; we are going to provide health care for you.

All these issues have been difficult, draining, wrenching issues, and they have all provoked great criticism and great anger, in many cases. This issue of health care brought to the floor of the Senate—I, perhaps, would have a different view of what is the priority.

I have spent most of my time saying: The economic engine, restart the engine, get people back to work. But that does not mean health care is not important. It is. Health care continues to gobble up more and more of this country's economy. At some point, somebody has to say: How do we stop that? If we are spending much more than anybody else, how do we fix this?

That is what this is about. It is going to take some courage to do it. One piece of it is this issue of prescription drugs and pricing. Some of us have been working on this for a long time. The breadth of the support of this issue in this Chamber extends from the late Senator Ted Kennedy, who sat in that seat back there—and God bless his memory—to JOHN MCCAIN over there; it extends to Senator CHUCK GRASSLEY, DEBBIE STABENOW, AMY KLOBUCHAR—a whole series of Republicans and Democrats who have come together to say: You know what, let's make sure there is fair pricing of prescription drugs for the American people.

We are not asking for anything other than fair pricing. How do you get it? My goal is not to ask the American people to buy their prescription drugs overseas. My goal is to say, if we allow the American people the freedom to do that, the pharmaceutical industry will be required to reprice their drugs in this country. It is as simple as that.

I know others wish to speak. As I said, I have a lot to say tomorrow. I am going to go home kind of upset about this letter today from the FDA, which is, in my judgment, completely bogus. I will read it tomorrow. I am not surprised. I expected this. I heard rumors about it.

Tomorrow my hope is with my colleagues—Republicans and Democrats—we will pass this legislation at last, at long last. Many of us have been working on this issue 6, 8, 10 years. We will pass this legislation. Why? Because this is the place for it. This is the bill that should be amended. This is the time to do this. We cannot walk out of this Chamber and say something happened in that Chamber to deal with health care. But did you do something about prescription drugs? No, no, we couldn't do that, couldn't do that. This is not the way I want this to end, and

it is not the way it has to end if enough of us have the courage to take on this fight.

As I said, I will have a lot more to say tomorrow morning. I appreciate the indulgence of my colleagues to listen tonight about why we have offered this legislation.

I started and let me finish by saying this is broadly bipartisan. It is, first and foremost, a Dorgan-Snowe bill. Senator DORGAN—myself—and Senator SNOWE from the State of Maine, but many others—my colleague, Senator GRASSLEY, who is on the floor, Senator MCCAIN, who spent a lot of time on this issue—Republicans and Democrats have come together.

By the way, this has not happened very often on this bill. But this is a bipartisan bill with Republicans and Democrats pulling their oars together to try to get this done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, before the Senator from North Dakota leaves and before I speak on another issue, I wish to tell him I am going to speak in support of his amendment. But I would like to ask him a question now, if he will answer it for me—a friendly question, but it is something I don't know absolutely for sure, but I believe that pharmaceuticals are about the only thing a consumer in the United States cannot buy anywhere in the world that they want to buy. We ought to give them that same right we do on everything else. There may be some other items I am not aware of, but I think it is only pharmaceuticals that you cannot import from wherever you want to buy them.

Mr. DORGAN. Madam President, I say to the Senator from Iowa, that and Cohiba cigars from Cuba, I reckon. We have a special embargo with respect to Cuba. With that exception, I don't think there is a legal product the American consumer cannot access anywhere else in the world.

This is about giving the American consumer the freedom that the global economy should offer everybody. The big shots got it. The big interests can do it. How about the American people having the opportunity to shop around the world for the same product and pay a fraction of the price of the charges that are imposed on them in the United States.

Mr. GRASSLEY. I thank the Senator from North Dakota.

I would like to talk about a recent news—

Ms. KLOBUCHAR. Madam President, we had a unanimous consent agreement. I am trying to figure out the order.

The PRESIDING OFFICER. Under the previous order, the next speaker is to be the Senator from Minnesota, followed by the Senator from Delaware.

Mr. GRASSLEY. I ask unanimous consent to speak now, if I may.

The PRESIDING OFFICER. Is there objection?

Mr. KAUFMAN. Will the Senator yield for a question? How long will the Senator be?

Mr. GRASSLEY. Fifteen minutes.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Madam President, I believe our speeches are 10 minutes long. If the Senator from Iowa could wait for 10 minutes, then we will be able to complete our speeches, as recognized by the Chair.

Mr. GRASSLEY. I will let the Senators speak, and I will speak tomorrow because I have to go to a meeting. I will let the unanimous consent agreement stand.

Ms. KLOBUCHAR. I was not aware the Senator from Iowa had to leave. If he can keep it to 10 minutes, that would be helpful.

Mr. GRASSLEY. I cannot keep it to 10 minutes, and I cannot shorten it. So I will let the unanimous consent agreement stand.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. KAUFMAN. Madam President, the Senator from Minnesota and I are going to engage in a colloquy.

We rise to talk about health care fraud enforcement. It is no secret fraud represents one of the fastest growing and most costly forms of crime in America today.

In no small part, our current economic crisis can be linked to financial fraud, starting with unchecked mortgage fraud generated by loan originators through securities fraud that hastened the eventual market crash and maximized its impact on Main Street and the average American investor.

In response, this body passed the Fraud Enforcement Recovery Act, which directed critical resources and tools to antifinancial fraud efforts. I was proud to work on FERA with my friend from Minnesota, a former prosecutor, who understands both the harm that financial fraud causes ordinary Americans and the importance of deterring criminal behavior before it happens.

Ms. KLOBUCHAR. Madam President, I thank Senator KAUFMAN. Before I begin, I wish to, first, acknowledge the amendment that has been offered by Senator DORGAN on drug reimportation, something I support and I know Senator KAUFMAN supports as well. We look forward to talking about that amendment in the days to come.

The bill Senator KAUFMAN referred to, the Fraud Enforcement and Recovery Act, was passed in response to an unprecedented financial crisis.

I was proud to work on that bill in the Senate Judiciary Committee along with Senator KAUFMAN.

But Americans should expect Congress to do more than simply react to crises after their most destructive impacts have already been felt. We are always coming in after the fact and putting out the fire. That is not what we want to do. We owe it to our constituents to be proactive, to seek out and to

solve problems on the horizon so that financial disasters can be averted.

In the midst of the debate concerning comprehensive health care reform, we must be proactive in combating health care fraud and abuse. Each year, criminals drain between \$72 billion and \$220 billion from private and public health care plans through fraud, increasing the costs of medical care and health insurance and undermining public trust in our health care system. Think of all the money wasted—\$72 billion to \$220 billion each year—drained by criminals, that could be going to our seniors, that could be going for care.

Let me give a couple of examples, Senator KAUFMAN, of the kinds of fraud we need to address. On June 23 of this year, eight individuals were indicted in Miami for cashing \$30,000 to \$80,000 several times a week at two check-cashing facilities they owned themselves. These crooks defrauded the U.S. health care system by creating a phony clinic that churned out medical bills in five States. They were not providing health care. They were phony clinics. Federal prosecutors announced this on Tuesday.

Some of the purported clinics were empty storefronts with handwritten signs while others existed only as post office boxes, but none provided any actual medical services, according to prosecutors. By the time they were caught, in this one incident, this one group of con men, had bilked the government of \$100 million. That is \$100 million at a time when our taxpayers are trying to save every dime, while they are holding on to their jobs and trying to pay their bills. This one group of con men—\$100 million.

Here is another example. In November of 2007, the Department of Justice indicted a woman for billing Medicare for motorized wheelchairs that beneficiaries didn't need and for children's psychotherapy services never provided. According to the indictment, the woman then laundered the money through a Houston check-cashing business, cashing several Medicaid checks each for more than \$10,000. Those are just examples of what we are dealing with.

Mr. KAUFMAN. I say to the Senator, those are sobering examples of the kinds of fraud we must stop. As we take steps to increase the number of Americans covered by health insurance and to improve the health care system for everyone—and we will do that—we must ensure that law enforcement has the tools it needs to deter, detect, and punish health care fraud.

The Finance and HELP Committees, as well as leadership, have worked long and hard to find ways to fight fraud and bend the cost curve down, and they have done a great job. But there is more work to be done. That is why Senator KLOBUCHAR and I, along with Senators LEAHY, SPECTER, KOHL, SCHUMER, and HARKIN, have introduced our health care fraud enforcement, No. 2792.

Ms. KLOBUCHAR. What I like about the amendment is it will protect our increased national investment in the health of Americans. We have decided Americans should be covered by health care; that people shouldn't be thrown off of their health insurance by pre-existing conditions. The way we protect that investment, and the way we make sure the funds are there to help people, is by doing things such as increasing the tools we need to prosecute these kinds of cases.

These criminals scheme the system to rob the American taxpayers of money that should be used to provide health care to those who need it most. We must put a stop to this, and we are doing that with this amendment. It provides straightforward but critical improvements to the Federal sentencing guidelines, to health care fraud statutes, to forfeiture, money laundering, and obstruction statutes, all of which would strengthen prosecutors' ability to combat health care fraud.

As a former prosecutor, I can tell you that when we had these types of cases, we used every tool you could use to push someone to plead guilty, every tool you could use to make sure you got the maximum sentence so a message would be sent not just to that particular criminal but to other white collar offenders who thought this might be a quick way to make a buck. They need to hear they can be caught and they will go to jail.

I know Senator KAUFMAN has worked on this and is taking a lead, and perhaps he can provide the details on this amendment.

Mr. KAUFMAN. Sure. This amendment directs a significant increase in the Federal sentencing guidelines for large-scale health care fraud offenses. It is incredible that despite enormous losses in many health care fraud cases, analysis from the U.S. Sentencing Commission suggests that health care fraud offenders often receive—and I know this is hard to believe—shorter sentences than other white collar offenders in cases with similar loss amounts. For some reason, people think health care fraud is kind of okay.

Ms. KLOBUCHAR. If people knew this, they would be shocked. In health care fraud, you are taking money from people who need it most—when they are at the hospital—and yet they would have shorter sentences than other types of fraud.

Mr. KAUFMAN. There is data to show that criminals are drawn to health care fraud, when they are sitting around deciding what kind of fraud they are going to do, because the risk-to-reward ratio is so much lower. That is ridiculous. We need to ensure these offenders are punished not only commensurate with the costs they impose on our health care system but also at a level that will offer real deterrence. People have got to understand they can't go out and commit health care fraud.

There are so many different ways it can be presented; that if in fact they do

it, they are going to get real time for the crime. As a result, our amendment directs changes to the sentencing guidelines that, as a practical matter, amount to sentence increases of between 20 and 50 percent for health care fraudsters stealing over \$1 million.

Ms. KLOBUCHAR. The other thing that is great about this amendment is it updates the definition of "health care fraud offense" in the Federal criminal code so it includes violations of the anti-kickback statute, the Food and Drug and Cosmetic Act, and certain provisions of ERISA. These changes will allow the full array of law enforcement tools to be used against all health care fraud.

The amendment also provides the Department of Justice with subpoena authority for investigations conducted pursuant to the Civil Rights for Institutionalized Persons Act—also known as CRIPA. Under current law, the Department of Justice must rely upon the cooperation of the nursing homes, mental health institutions, facilities for persons with disabilities, and residential schools for children with disabilities that are the target of these CRIPA investigations. While such targets often cooperate, they sometimes do not, and the current lack of subpoena authority puts vulnerable victims at needless risk.

Finally, in addition to the very important piece of this amendment that Senator KAUFMAN has pointed out—where we are actually increasing the ability to get better criminal penalties—the amendment corrects an apparent drafting error by providing that obstruction of criminal investigations involving administrative subpoenas under HIPAA—the Health Insurance Portability and Accountability Act of 1996—should be treated in the same manner as obstruction of criminal investigations involving grand jury subpoenas.

Senator KAUFMAN and I also plan to file an additional health care fraud amendment that would require direct depositing of all payments made to providers under Medicare and Medicaid. This amendment is incredibly important because the Medicare regulations already require direct depositing or electronic transfer, but these regulations have not been uniformly enforced and criminals are taking advantage of this system.

Again, I ask the question: Why would we want this money—\$60 billion estimated for Medicare fraud alone—to be going to con men and crooks, people who are setting up fake storefronts with fake signs that say doctor's office, instead of to the hard-working people in this country who can hardly afford their health care insurance? It is an outrage.

That is why I am so glad Senator KAUFMAN would take the leadership here, that we have a group of us who were prosecutors working on this in the Judiciary Committee to include this in the health care reform bill, be-

cause Americans have waited too long for these kinds of changes.

Mr. KAUFMAN. That is a great amendment that I think will be a big help in terms of cutting down this fraud, and that is what we are all about. This is a bipartisan issue, if there was ever a bipartisan issue. I don't know of anyone who doesn't think we have to do more in terms of health care fraud. When we have \$70 billion to \$220 billion a year in health care fraud, we have to do everything we can to stop it.

As we consider and debate meaningful health care reform, we must ensure that criminals who engage in health care fraud—and more importantly those who contemplate doing so—understand that they face swift prosecution and substantial punishment.

When the time comes, Senator KLOBUCHAR and I, along with our fellow cosponsors, will urge our colleagues to support these amendments.

Madam President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. KAUFMAN. Madam President, I ask unanimous consent to speak as in morning business.

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

#### AFGHANISTAN STRATEGY

Mr. KAUFMAN. Madam President, I rise today to speak about the Afghanistan strategy President Obama announced last week. The dilemma facing the President and our national security team in Afghanistan is one of the most complex and difficult I have seen in more than three decades of public service.

President Obama's speech laid out a bold plan, and he has been both deliberative and courageous in his approach. At the same time, I share the concerns of many Americans about the challenges that lie ahead for our troops. Sending young men and women into harms way is the most difficult choices we must face. Each life lost is one too many.

The decision in Afghanistan is especially difficult because four primary questions remain. The first question is do we have a trusted and effective partner in President Karzai? No matter how many troops we deploy, we cannot succeed with an Afghan government plagued by corruption.

The second question is to what length is Pakistan willing to go to help? We cannot defeat al-Qaida and degrade the Taliban without Pakistan's support.

The third question is can we accelerate the training of Afghan National Security Forces? Today, there are too few Afghan security forces to clear and

hold against the Taliban, and they are not capable of taking over from U.S. troops. And in light of the President's 18-month deadline, it is clear that self-sufficiency for the Afghans is not optional; it is mandatory. Secretary Gates confirmed for me in last week's Senate Foreign Relations hearing that July 2011 is a firm deadline. In 18 months, we will begin our withdrawal and we will not send additional troops after this time. This was reiterated by Secretary Clinton and Chairman of the Joint Chiefs Mullen.

The fourth question is do we have enough qualified U.S. civilians in Afghanistan to partner with the Afghan people in promoting governance and economic development? We must send even more and ensure that the "civilian surge" extends to all 34 provinces, so they can partner with Afghans in the field.

I visited Afghanistan in April and September and had the opportunity to speak with our military and civilian leaders, President Karzai, and numerous Afghan ministers. I traveled to Helmand and Kandahar Provinces, and met with local government officials and tribal elders at a "shura," or community council. What I heard from the Afghan people was frustration with their government's inability to provide security, administer justice, and deliver basic services. They welcomed international assistance in the short-term but sought improved security and governance. Most importantly, they wanted control transferred to Afghan security forces once they were capable of holding against the Taliban themselves.

Since returning from Afghanistan, my No. 1 concern has been the ability of the Karzai government to be an effective and trusted partner. In his second term, President Karzai must eliminate corruption, strengthen rule of law, and deliver essential services in order to win the trust of the Afghan people. Ultimately, the battle is not between the U.S. and the Taliban. It is a struggle between the Afghan government and the Taliban, and the fight must be won by the Afghans themselves. The notion of a corrupt government has emboldened the Taliban and further undermined trust between President Karzai and his people. President Karzai must translate promises in his inauguration speech into action, because increased government transparency and accountability is absolutely critical.

For me, the key point in President Obama's speech was that our military commitment is not open-ended. In July 2011, we will begin our troop drawdown. This has created an 18-month deadline for progress, injecting a sense of urgency to our mission that has been missing for the past 8 years. It sends a message that the clock is ticking for the Afghan government to eliminate corruption. They will no longer get a "blank check" because the time for action is now. On the security front, the

Afghan National Army and Police have no choice but to assume greater responsibility given the certainty of a U.S. withdrawal.

As President Obama outlined, Pakistan is central to this fight. We cannot succeed without its cooperation because developments in the region are inextricably tied to both sides of the border. After my April visit, I was concerned about the Pakistani commitment. When I returned in September, however, I was impressed by the Pakistani military's decision to go after elements of the Taliban in the Swat Valley and South Waziristan. At the same time, Pakistan must take action against the Afghan Taliban and al-Qaida, which continue to find safe haven in Pakistani tribal areas. If extremists continue to operate freely between Afghanistan and Pakistan, it will undermine security gains made on the Afghan side of the border. And the stakes are even higher in Pakistan, which has both nuclear weapons and delivery vehicles.

In Afghanistan, we must break the momentum of the Taliban by improving security and strengthening our ability to partner with the Afghans. That is why I support efforts to accelerate the training of Afghan National Security Forces, ANSF. I am concerned that the President's goal of increasing the Afghan Army to 134,000 in 2010 does not go far enough in building the capacity of the ANSF. By comparison, Iraq—a geographically smaller country with the same sized population—has 600,000 trained security forces. This is why we must accelerate our targets for building the army and improve the capability of the police, which has faced even greater challenges in terms of corruption, incompetence, and attrition.

Finally, our success in Afghanistan depends on more than troops—we need an integrated civilian-military strategy in order to sustain progress. Many dedicated U.S. civilians continue to serve in Afghanistan, and we must further augment these numbers and ensure they can directly interact with Afghans in the field. Given their role as a force multiplier for the military and international nongovernmental organizations, NGOs, this is an area where we must channel even more resources and people in the near term. We need a stronger civilian capacity, because counterinsurgency cannot and should not be conducted with the military alone.

Over the coming months, I will closely monitor our progress in Afghan governance, partnering with Pakistan, building the Afghan National Security Forces, and increasing the U.S. civilian surge. Improvements in these areas are critical to our overall success in Afghanistan, and will determine when our brave men and women in uniform can return home.

I yield the floor.

Mr. SESSIONS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. The Senator from Alabama. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I see my good friends, Senators KAUFMAN and KLOBUCHAR, had talked about actions we could take to deal with fraud in health care. I support that. I had the opportunity in the past, as U.S. attorney, to lead a group that would do that. But something is troubling me today a great deal. I am uneasy about it. It goes to the heart of how the legislation that is before us today has been put together.

Earlier today, we had Senator MCCAIN offering an amendment to say that every State should have the same policies with regard to Medicare Advantage that the State of Florida will under this bill. Presumably, that was an effort to gain some support. We have seen other situations such as that with Louisiana and other places getting special advantages.

Let me tell you about something that is particularly troubling to me. It was written about by Robert Reich, who was Secretary of Labor in President Clinton's Cabinet. He is a prolific writer about economic and health care matters. He starts his Sunday August 9 article this way on his blog. It says:

I'm a strong supporter of universal health insurance—

He is not pulling any punches there. He believes in a single-payer government policy. Then he goes on to say—and a fan of the Obama administration. But I am appalled by the deal the White House has made with the pharmaceutical industry's lobbying arm to buy their support.

That is a pretty serious charge. He goes on to say:

Last week, after being reported in the Los Angeles Times, the White House confirmed it had promised Big Pharma that any healthcare legislation will bar the Government from using its huge purchasing power to negotiate lower drug prices. That's basically the same deal George W. Bush struck in getting the Medicare drug benefit, and it's proven a bonanza for the drug industry.

I will say, as I recall, that Mr. Reich was a critic of that at the time. Right or wrong, it was done and he was a critic of it. I give him credit for it. He said a continuation of that would be an even larger bonanza. He goes on to describe why he thinks it is a bonanza.

Right or wrong, as a matter of policy and so forth, it is no doubt that is something Big Pharma would like. He goes on to say this:

In return, Big Pharma isn't just supporting universal health care. It's also spending lots of money on TV and radio advertising in support. Sunday's New York Times reports that Big Pharma has budgeted \$150 million for TV ads promoting universal health insurance, starting this August—

I am quoting him—

(that's more money than John McCain spent on TV advertising in last year's presidential campaign), after having already spent a bundle through advocacy groups like Healthy Economies Now and Families USA.

I don't know what has happened. There is a memorandum in, I believe, one of the blogs here, the Huffington Post. That is supposed to be the memorandum that documents the agreement. I don't know what the facts are, but I know this, it is not a healthy thing, as somebody who has been involved in Federal law enforcement, for a government official, under color of right, to say to a private individual that you will help me with an advertising campaign and spend your private money, or I will do you a favor in exchange for an \$150-million television campaign.

I wish to tell you that is not good. That is beyond the pale. If things such as this have been done in the past, it is not the kind of thing that ought to be continued. I think it is a big deal.

The New York Times has reported, as they go forward:

Shortly after striking that agreement, the trade group—the Pharmaceutical Research and Manufacturers of America, or PhRMA—also set aside \$150 million for advertising to support health care legislation.

I am quoting a New York Times article by Duff Wilson.

But an industry official involved in the discussions said the group and its advertising money would now be aimed specifically at the approach being pushed by Mr. Baucus, Democrat of Montana and chairman of the Senate Finance Committee.

Is that the way this thing is being done? I hope not. I will examine these circumstances in more detail, but I would like to say, right now and today, that I am not happy about it. I don't like the looks of it, it doesn't smell good to me, it does not strike me as something that is legitimate, and I think maybe we need to find out more about it, frankly.

I wish to share with my colleagues a fundamental concern I have with this health care bill. Supporters of the bill have made a great deal of promises. They alleged it would do a lot of very great sounding things, and we were asked to support it on the basis of their promises. But a careful examination of the legislation shows it fails to deliver on almost all the major promises it made and is likely to cause a great deal of adverse, unanticipated consequences. As a result, I think the American people have intuitively understood this; that is, why they are so strongly opposed to it. They cannot imagine why the leadership of this Senate continues to try to push down on their brow this piece of legislation that does not do what it promised to do.

For example, the sponsors of the legislation say the bill's total cost is \$848 billion. However, they do not begin the benefits of the bill until 5 years after enactment and that \$848 billion is the cost of expenditures over 10 years. So

when you move forward to when the benefits actually start for those who will be receiving them and go 10 years from that point, the total costs are not \$848 billion, they are \$2.5 trillion. That is a huge difference. It is a monumental difference. It is a difference so large I cannot understand how we can, with a straight face, try to contend that we have a sound budget-minded bill that is going to cost \$848 billion, and we have tax increases of about half of that, and raids on Medicare for about half of that and that is how we are going to pay for it. It is not working in that way, in my view.

Another promise for the bill that was made by the President in the joint session to the Congress, he said this:

This bill will not add one dime to the deficit.

That is just not accurate. You can make anything deficit neutral if you pay for it by slashing Medicare and taking the money from Medicare to pay for it. Or you can make a bill be deficit neutral if you raise enough taxes. So they are raising \$494 billion in taxes. They are cutting Medicare by \$465 billion. That is the plan.

They claim they have a \$130 billion surplus. So don't worry about the budget. We have created a bill that is going to reduce the deficit. That is what they have said repeatedly.

But they forgot something. They forgot we have to pay our physicians. That was always supposed to be part of health care reform. In fact, the physician groups were told they were going to be paid. But under this bill, to show you how it has been doctored—and this has been done before, Republicans have participated in this in the past, and it has been something that has been going on for a decade, but it is really relevant today, particularly in this legislation because this legislation was supposed to fix this problem—they keep the physician rates slightly above last year's rate for 1 year. Then for 9 years in the 10-year budget, they assume that doctor payments, physician reimbursements are going to be cut 23 percent. That is unthinkable.

We are not going to cut physicians 23 percent. We can't cut the physicians at all because they are already wondering whether they will continue to take Medicare patients and, even more so, Medicaid patients, where they get paid less.

We could have a mass walkout of physicians who couldn't afford to see seniors if we were to cut their pay by 23 percent. In fact, we are not going to do that. We all know this. So what did they do? I know they were meeting down in the hallways somewhere, and they were plotting out this bill. They said: The President said it will not add to the debt. What are we going to do? The numbers don't add up. We can't raise taxes any more. We can't cut Medicare any more. We have done all we can do. What are we going to do?

So what they obviously decided was to take the physician pay portion of

the bill out, that one that would have fixed this aberrational law we have that requires it to be cut 23 percent, and so they put it in a separate bill. Every penny of this separate bill would be paid for by increased debt, so not really paid for at all. They offered that bill on the Senate floor, and it got voted down because Republicans all voted against it as being utterly fiscally irresponsible. Enough Democrats joined in to kill the bill. They wouldn't support it either. A number of Democrats know the budget has to have some rationality. So they failed to do that.

But if you put the doctor fix in, you are increasing the costs of the bill by \$250 billion, so the \$130 billion surplus is reduced to a \$120 billion deficit. So it does add to the deficit. It adds more than one dime to the debt; it adds \$120 billion to the debt.

Another fiction was their promise that they would fix the physician payments and make a permanent policy of paying them so every year they wouldn't have to run to Congress and hire lobbyists to come here and meet with Senators to beg them not to have a 23-percent cut. That happens every year. It is ridiculous. But this bill does not deal with that. It only has a 1-year fix, and for 9 years it is reduced just like it has been done in the past. There is no reform in that part of health care that needs to be done.

Another fiction is that they are not cutting Medicare benefits. They say: We are not cutting Medicare benefits. We are cutting that bad old Medicare Advantage that 11 million seniors are benefiting from and enjoy and participate in. They are cutting that \$100-plus billion which is about one-fourth of what the cuts to Medicare are. They say that is not truly cutting Medicare. But that clearly is cutting Medicare because Medicare Advantage is part of the Medicare Program. It is cutting Medicare. However you feel about Medicare Advantage, this is a cut to Medicare Programs that millions of seniors favor.

That is why Florida didn't want to have their Medicare Advantage cut. So they got a special deal in this legislation. Everybody else in America won't get that. They want to keep it.

Let's go on a little bit further just to show you why the American people are unhappy with Congress. They have a right to be unhappy. People say: Those people out there at the tea parties and townhall meetings, they were just upset. They are poor Americans. They are not good Americans. Good Americans would come in and say: How much more money can we give you, big government, to take care of all our needs from cradle to the grave?

The people at the tea parties understand the kind of games that are being played here. They understand the cuts to home health care, to hospice programs, to hospitals, the hospitals that care for a disproportionate share of the poor people, and the \$23 billion from

just general Medicare accounts represent cuts to Medicare, which is our seniors program.

How is it, then, that we have this disagreement? How is it possible that you can't agree on where \$465 billion comes from? The sponsors of the bill, this is what they say. They say: We promised we wouldn't cut Medicare benefits. Any guaranteed benefit any senior citizen has, we promised not to cut it. All we are doing is cutting the providers, the people who provide the benefit.

Give me a break. So you come in and you cut hospice, nursing homes, other providers, \$118 billion from Medicare Advantage, \$192 billion from the hospices, nursing homes, and other providers, \$43 billion from hospitals that serve a disproportionate number of poor and uninsured, \$23 billion from unspecified Medicare accounts, and that this doesn't weaken Medicare. If we could cut that, why haven't we done it already? If this didn't reduce the quality of care for seniors, if we could reduce these hospitals and others and they could still provide care to our seniors, why haven't we done it already?

Mike Horsley, head of our hospital association in Alabama, tells me that as a result of an abominable wage index program that helps to determine how much hospitals get paid primarily and lien payments in general, two-thirds of the hospitals in Alabama are operating in the red. They don't need to be cut any more.

I guess what I would say is, this is the way the game has been played. My colleagues are saying we are not cutting guaranteed benefits. We are just cutting the money from the people who provide the benefits. How many of them are going to keep doing so, as the CMS Actuary's report questioned? How many of those will give it up?

Fiction No. 6—I have 10, and I will not go through all of them tonight—is that hospitals that treat the poorest and sickest will somehow be better off under this program. But they are not feeling that way. They are not feeling they are going to make up for the fact that the hospitals that qualify as disproportionate share hospitals, those who serve a high percentage of individuals who are very low income or who have no insurance, they are going to lose \$43 billion in cuts under this bill. These hospitals that provide so much charity care and provide a safety net in the communities are going to suffer under this legislation. They are telling me that. I don't know who in Washington may say they are not, but that is what they are telling me. I think they are telling the truth.

Fiction No. 5 is that average family premiums are going to decrease. Have you heard that through this proposal? Senator EVAN BAYH asked the CBO about this, and they said families who do not receive coverage from their employer would see their premiums rise "about 10 to 13 percent higher by 2016" than under the current law. The ones who claim they are seeing some reductions, those reductions are only the

slightest reduction, less than 3 percent in most cases, of the 5- or 6-percent increase expected to occur every year under current law.

So instead of going up 5.56 percent, it goes up 5.41 percent. They are claiming, I guess, that is some sort of cut. But it is misrepresentation to say that family premiums are going to decrease, when people who are not in group health plans through their employers are the ones who are going to see the largest increases, perhaps 10 to 13 percent by 2016, more than would occur under present law.

I am pleased to be able to serve in the Senate with Senator GRASSLEY who chaired the Finance Committee, is ranking member now, who does over 100 townhall meetings a year or something in the counties in Iowa. He met with thousands of people and got the same message I got, which is you people are irresponsible. The debt is surging and will double in 5 years, the whole debt of America, and triple in 10. I want to say that the American people are concerned about this. Senator GRASSLEY worked so hard to see if he could get a bill that would be bipartisan, that we all could support, or large numbers of the Senate could support. But we got off track.

I talked to one person who dealt with this issue. He said the way things got off track was that we abandoned ways to legitimately contain costs increases. The way to create more competition, the more personal stake in your health care, other things that would actually help reduce the cost of health care, is what we got away from, and it became driven by President Obama's determination to have a government option. That, in my estimation, may have been the decisive event in the negotiations breaking down.

This is a serious piece of legislation. It seeks to alter one-sixth of the American economy. It does not do what it promises. It surges spending. It increases taxes dramatically. It represents a major governmental takeover and will ultimately undermine the special relationship between patients and their doctors. It will also substantially threaten the viability of Medicare. This money that is being taken out of Medicare will only accelerate its insolvency. By 2017, Medicare—I believe Senator GRASSLEY will agree—is expected to go into default. It will go down rapidly, actually.

Is that correct, Senator GRASSLEY, that by 2017, under current law, Medicare is projected to go into default and go rapidly into default, and if we could save any money out of Medicare, if we can save \$400 billion, shouldn't it be kept in the Medicare Program to try to extend its life and make it a viable program that seniors can rely on rather than creating a whole new spending program with that money?

Mr. GRASSLEY. Mr. President, if the Senator is asking me that question, I will tell him that he is absolutely right, not based upon what I say or

what the Senator says, but every spring the trustees of Social Security and Medicare look ahead 75 years and they predict what the income and the outlays are going to be based upon the population and the projected growth of the economy and all that stuff. Right now, they are projecting \$37 trillion of shortfall over that 75-year period of time. They already told us, and it has materialized, that in the year 2008 we started paying more money out of Medicare than was coming into Medicare, and by the year 2017, as the Senator correctly stated, the trust fund will be out of reserves.

Mr. SESSIONS. So we are spending the reserves in Social Security, which will be exhausted by 2017.

Mr. GRASSLEY. In Medicare.

Mr. SESSIONS. Medicare. Excuse me.

I am going to yield the floor to Senator GRASSLEY. I say to the Senator, I appreciate your leadership and insight into this issue. I value your whole approach to it. I think most Americans—if they understood this information as the Senator does and as the Senator has articulated, the opposition to the bill would be even greater than it is.

I urge my colleagues to examine the fact that the bill simply does not do what it sets out to do. It does not meet its promises, and as a result, we absolutely should not go down this road to a major Federal takeover of health care, with ramifications that go far beyond what it might appear today.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I had a chance to hear a great deal of what the Senator from Alabama said. I think I would highlight that what he said is what he is hearing from the grassroots of his State, which is very much what I hear from the grassroots of my State: people are very concerned about this piece of legislation leading to the nationalization of health care, similar to what they have seen this administration previously do this year with the nationalization of General Motors, partial nationalization of the financial system—a big deficit. And then they see the money being spent on this bill—\$2.5 trillion after it gets fully implemented. And where are you going to get money? And what is that going to do to the economy? And, more importantly, what sort of a legacy is that leaving to our children and grandchildren?

He also correctly stated that I do visit every county every year. The number of counties the Senator had was just a little bit high. We only have 99 counties. But for the 29 years I have been in the U.S. Senate, I have held a town meeting in each one of our counties every year. So I do have the benefit of 2,871 town meetings as a basis for suggesting what people tell me face to face, besides the large number of phone calls we get.

You cannot believe the number of phone calls that are coming in now, the

number of e-mails we are getting—historically high. I have never had that before on any issue. I assume it is the same for the State of Alabama, contacting their two Senators as well.

Mr. President, I rise to bring up an issue that is a relatively new issue in this debate, as in the secrecy of the negotiations that are going on around Capitol Hill on the issue of health care reform. These secret negotiations actually started about October 2 when Senator REID, the leader, had to merge the bill out of the Senate Finance Committee and the bill out of the Senate HELP Committee into one bill. It took a long period of time to do that.

We are in the second week of debate. I hope people realize that 99 Senators ought to have the same privilege that 1 Senator had of getting a grasp of this huge 2,074-page bill. There are still negotiations going on because the leader still does not have locked down the 60 votes that it is going to take to get to finality.

So some of these discussions are: what can we do to get a few votes if we do not have a so-called public option? And the latest of that is: Well, allow people to buy into Medicare. So I want to speak about that issue because it sounds pretty simple. It may get 4 more votes and may get 60 votes, but it is bad. It may be good politically, but it is bad for Medicare and particularly for Medicare in rural areas where we have a difficult time keeping hospitals open, and we have a difficult time recruiting doctors in rural America.

So I would talk about the recent news reports of a proposal being concocted behind closed doors to allow 55- to 64-year-olds to buy into the Medicare Program. Supposedly, this idea has been put on the table to get the votes for supporters of having a brandnew government-run health plan and the people who do not like that.

Back in the spring, such a proposal came up during the early stages of our Finance Committee's health care reform efforts. The idea was originally proposed by President Clinton even going back to 1998. I opposed such a proposal back then, and I oppose such a proposal now. I oppose the proposal because of its negative effect on the Medicare Program and our senior citizens who use Medicare.

The best way to describe the effect of this proposal on the Medicare Program and its beneficiaries is to quote former Senator Phil Gramm of Texas when he was asked about President Clinton's proposal when President Clinton put that proposal on the table back in 1998. Senator Gramm said this about President Clinton's proposal, which would be applicable today as our colleagues are studying it:

If your mother is on the Titanic, and the Titanic is sinking, the last thing on Earth you want to be preoccupied with is getting more passengers on the Titanic.

Since its inception in 1965, the Medicare Program has helped ensure senior

access to health care. But, as the Senator from Alabama and I were just discussing, the problems with health care and Medicare are such that Medicare is already under extreme financial pressure. So why would you load more people into a system that Senator Gramm of Texas was referring to as the Titanic? You would not load more people on it as it was going to sink.

This is not to say that this entitlement program, Medicare, is not in need of improvement, but having the 36 million Americans who are age 55 to 64 buy into the program is not an improvement. Even groups supporting the Reid bill, such as the AARP, are pointing out the severe shortcomings of such an approach.

Last summer, the AARP Public Policy Institute published an analysis of the Medicare buy-in concept. In their report, the AARP points out the potential for increased Federal entitlement spending. AARP said:

Expanding the program to more people could raise federal spending even further if their care is made affordable through subsidies that would be funded by the existing Medicare trust funds.

And do not forget the effects of adverse selection from a Medicare buy-in program. Here AARP has studied it, and this is what they say about that:

... the premium may be too uncompetitive for those who don't use much health care and unaffordable for those with modest incomes. This may limit buy-in enrollment and drive up cost further.

So this means that this buy-in proposal is likely unsustainable. And we all know what happens when the government creates an unsustainable new program. What happens? The taxpayers end up on the hook for bailing it out down the road sometime.

We all know the Medicare Program has \$37 trillion in unfunded obligations. We all know about the pending insolvency of the Medicare Program. The trustees say so every spring.

The Medicare hospital insurance trust fund started going broke last year. In 2008, the Medicare Program began spending more out of this trust fund than was coming in through the payroll tax. The Medicare trustees have been warning all of us for years that this trust fund is going broke. They now predict that it will go broke right around the corner in 2017. Well, as the AARP has pointed out, adding millions to the Medicare Program would almost certainly make things much, much worse for the fiscal health of a program that is not in very good financial shape. This proposal would also make things worse for the 45 million Medicare beneficiaries who paid into the program over the years and are receiving benefits under the program.

Since we started debate on this 2,074-page bill, Members on this side of the aisle have questioned the wisdom of slashing Medicare by \$½ trillion and then using the savings to start a new Federal entitlement program. We on

this side have stressed that provider cuts of this magnitude will make it financially harder for providers to care for beneficiaries. We have pointed out that this will worsen beneficiary access to health care, as providers stop treating Medicare patients.

Adding millions more Americans to Medicare on top of the \$½ trillion in Medicare cuts in this Reid bill would make beneficiaries' access to care much worse. But do not take my word for it. Even national hospital associations such as the American Hospital Association and the Federation of American Hospitals are opposing this proposal. They are mobilizing their ranks against this proposal even as I speak. Yes, the same groups that agreed already—and this was back in June—to \$155 billion in Medicare cuts—and they did that in an agreement with the White House and got sweetheart deals in this bill—do not want the Senate to go the route of expanding Medicare for people under 65 years of age. The American Medical Association has also opposed this proposal. These groups recognize the potential for financial disaster by boosting the number of patients with coverage that pays well below cost.

This Medicare buy-in proposal would also jeopardize retiree benefits. Going back to the same AARP analysis that I have quoted, they concluded that a Medicare buy-in program could further reduce employer-sponsored health benefits.

According to the AARP:

... a buy-in program might displace retiree coverage now available through [their] employers.

Still quoting AARP, they said:

As health care costs tend to rise with age, employers might have the incentive to find ways to avoid offering private coverage for early retirees. . . .

So with fewer patients with higher paying private coverage, there is less opportunity for providers to cost-shift to make up for low Medicare payments, because everybody recognizes the Federal Government does not pay 100 percent of costs. This would make it even harder for providers to treat Medicare beneficiaries, and as a result, beneficiaries would have an even harder time finding a provider to treat them.

I come from a rural State where Medicare reimbursement is already lower than almost every other State in the Nation, so I have serious concerns about the ability of the Iowa providers to keep their doors open if more and more of their reimbursement is coming from Medicare. I know this is a concern that is shared by rural State Members of this body from both sides of the aisle. But losing providers to serve Medicare beneficiaries would only be the beginning of access problems caused by a Medicare buy-in program. Because if you think it would be tough to keep existing Medicare providers, think how hard it would be then to recruit new ones.

Provider recruitment is already a major problem in rural States, particu-

larly my State of Iowa. This issue comes up during my meetings with constituents in Washington or during the townhall meetings I hold in each of Iowa's 99 counties every year. It is already a challenge under the current Medicare Program for Iowa to compete for providers with urban areas where Medicare reimbursement is higher.

I hear countless stories from constituents where they make great efforts to recruit doctors only to lose them to areas where Medicare reimbursement is higher. The Medicare buy-in will only make this situation worse in my State of Iowa, because more and more reimbursement would come from Medicare. So the current and future Medicare beneficiaries would be assured of limited access to providers because of this buy-in.

AARP pointed out another flaw in this buy-in proposal. In their analysis, AARP warned that there are large cost-sharing requirements in Medicare, so buy-in enrollees would still be exposed to significant cost sharing. Maybe these buy-in enrollees would have the resources to purchase supplemental Medicare policies to defray these cost-sharing requirements. Perhaps AARP is thinking of making even more money by selling supplemental policies to these retirees.

I share the goal of getting more Americans covered, but expanding the Medicare Program to early retirees is not the answer. Medicare beneficiaries have paid in to this program all these years and rightfully have the expectation to receive the benefits to which they are entitled under the program. The Medicare buy-in proposal would jeopardize these benefits. It would jeopardize existing retiree benefits. It would leave retirees exposed to significant cost sharing. It would be unsustainable and taxpayers would end up footing the bill.

I yield the floor.

**THE PRESIDING OFFICER.** The Senator from Pennsylvania.

**Mr. CASEY.** Mr. President, thank you very much. I rise tonight to continue the discussion and debate on health care. I had the chance over the last couple of months not only to do a good bit of work on a number of issues that relate to the bill and the two bills that came before and were merged into one bill, but also to hear from constituents across Pennsylvania. Some of them are writing to us and urging us to pass a bill and some are urging us to go in the other direction. But the communications I get from people who write about their own stories, their own family, their own challenges are, of course, the most compelling and the most worthy of time and attention.

Often they come from Pennsylvania families who are not only facing health care challenges but facing economic challenges that I don't think anyone in this Chamber can fully understand, at least not at this point in someone's life. Because when you become a Member of Congress, you are usually in

pretty good shape. You may not have a lot of wealth, but you at least have a job to go to every day, you have a lot of people helping you, and you have health care. That is not something that can be said for tens of millions of Americans.

This legislation is the culmination of a lot of debate and discussion and analysis and study over many decades now. It is nice that we have been talking for years and years about preventing a pre-existing condition from barring someone's coverage or treatment. It is nice to talk about it, but it is a lot better when we do something about it. It is nice we have talked about limiting out-of-pocket costs for families who are trying to take care of their children, trying to care of themselves, but it is a lot better to do it, to enact it into law.

This bill makes it illegal to use pre-existing conditions to deny someone coverage. This bill makes it illegal for insurance companies to put a lifetime cap on services, or an annual cap. This bill makes it illegal to discriminate so that no longer, if we do what we must do and get this bill passed, can an insurance company discriminate against a woman, which they do all the time now, just as they prevent people from getting coverage due to a preexisting condition. We have an opportunity to change the way we provide health care in ways we haven't been able to imagine, let alone enact into law.

One issue that has motivated me throughout this whole debate is what happens to our children at the end of the debate, at the end of the legislative line, so to speak. Will children in America—and I am speaking about poor children and those with special needs because they are the ones who need help. If you are in a wealthy family, you will figure it out, and your family will figure it out. If you happen to be a child of a poor family or a child who has special needs, will you be better off at the end of this debate or will you be worse off.

As it relates to poor children and children with special needs, the goal here has to be no child worse off. It is very simple. It is a very simple test. That is what we have been working on. I believe this bill that is on the floor right now is a dramatic improvement in the lives of so many families. I still think we have some more work to do as it relates to children, but there is no question that the bill we are debating will make children a priority in ways we haven't been able to do in any kind of other legislation, other than the children's health insurance legislation that Congress enacted going back more than a decade ago and that we reauthorized this past year.

I wish to speak about two families tonight. This isn't a discussion about theory or about the nuances of a policy. This is about real people and what has happened to them under our existing system. I wish to put up the first chart. This chart depicts one family,

the Ritter family in Manheim, PA. I spoke with them several days ago and I spoke with these two young girls. One daughter's name is Hannah—one twin, I should say, is Hannah and her sister—after I spoke on the floor I called their mom to talk about what I had said on the floor and I said to her, I think I referred to one of your daughters as Madeline, and that is incorrect, it is Madeline. So I want Madeline to know I correctly pronounced her name my second time around. Part of that is because of a story I read to my daughters when they were kids all the time. But there was a story about Madeline, and a lot of parents know that story. So I apologize to Stacie Ritter.

But here is the story that Stacie Ritter has told me through this communication, but has told a lot of other people, and now we try to tell her story on the Senate floor to give meaning to what we are talking about here. But this isn't some public policy discussion about health care; this is about what happens to real families when we don't get the policy right, when we talk and talk year after year, decade after decade, and talk about good intentions, but never get it done, never get a bill passed. This is what happens to people.

Stacie Ritter had to declare bankruptcy after her twins were diagnosed with leukemia at the age of 4. My wife Teresa and I have four daughters, and thank goodness they are all healthy. Two of them are in college, one is in high school, and one is in seventh grade. We have never had to face that kind of diagnosis, thank goodness. Thank God I have never had to face that, nor has my wife Teresa had to face that as a parent. But if we did, we would have been given some protection and so would our daughters if we faced that horrific diagnosis, because when I was working as a lawyer or when I was a public official, I had health care. Sometimes, for a lot of that time period, a decade in State government health care, because I was a State employee, I had a tremendous health care plan, a kind of public option, a good public health care plan. So I never had to worry about that as a parent nor did my wife if something horrific were diagnosed.

These two little girls pictured here—and you can see even though because of that diagnosis they are facing the kind of challenge I can't even imagine, let alone endure—I hope I could, but I am not sure I could if I were in their place. But you can see that even though it is obvious they are facing a real challenge with regard to the leukemia, they are very hopeful, aren't they, in that picture. They have their arms around each other. They have these stethoscopes and they are dressed up like two doctors. So even in the midst of the horror of that kind of a diagnosis, you have these two brave little girls who are looking forward, not just worried about their one situation but looking forward with hope and optimism.

Here is a picture down here taken last year in Washington, DC, then at the age of 11. Here is what their mother said:

Without meaningful health reform my girls will be unable to afford care, that is if they are even eligible for care, that is critically necessary to maintain this chronic condition.

Punished and rejected because they had the misfortune of developing cancer as a child.

What is the particular problem here with this case? The obvious problem is that these young girls were diagnosed with leukemia. That is bad enough. But we have a system that made their life a lot worse than the leukemia, because we had a system that said—basically what the system said to them is: We can help you and maybe cure you, but we are going to put limits on it. We are going to say that it is nice to have all of this technology and all of this great medical knowledge and great doctors and hospitals across America—and we do. We are the envy of the world on some of this stuff: the doctors and the nurses and the health care professionals, and the hospitals and the technology and the know-how. We are the envy of the world. We should acknowledge that. But then we have this ridiculous system that says to these two little girls: But the care we want to give you and the results we can get from that care are going to be limited. So we hope it works out for you.

That is ridiculous. It is an abomination. I don't understand why we have gone year after year and settled for this. Why do we have limits on the kind of care people get? Because insurance companies thought that was a good idea. I don't know why. I don't know whether it is for their bottom line or for whatever reason, but there is no excuse—no rationale—for saying to someone: We can cure you, but we are going to limit your care.

You are in real trouble, and we know how to help you. But we are going to limit it. Here is what Stacie said about her kids:

When my identical twins were both diagnosed with [this leukemia] . . . at the age of four, we were told they would need a bone marrow transplant in order to survive. That's when I learned that the insurance company thought my daughters were only worth \$1 million each.

I don't know a parent in America who believes their son or daughter—in this case, two daughters, her twins—is worth any amount of money or their care is worth any amount of money. Why does the insurance company do it? We hear they say that is policy, and then they get pressure from a TV station or news organization and they give the care.

If the policy makes sense, why would public pressure change a policy? The policy is ridiculous and insulting. It should be changed. It is one of those things we have to make illegal, and this bill does that. We should make it illegal for an insurance company to do that to children. But it doesn't make a

lot of sense unless you talk about it in terms of a real story.

Here is what Stacie Ritter said after she talked about the limit—very flatly, she said two words about whether a \$1 million is enough to care for two daughters with leukemia over many years:

It's not! When you add up the costs involved in caring for a patient with a life-threatening disease like cancer, \$1 million barely covers it.

We have lots of stories like this.

Fortunately, the hospital social worker recommended we apply for secondary insurance through the State considering the highly probable chance we would hit the cap. And we did hit that cap before the end of treatment.

The State program sounds a lot like a public option. I may be wrong, but it sounds an awful lot like that.

Thankfully, the State program kicked in and helped pay for the remainder of treatment.

So that part of the story worked itself out. It didn't work itself out because the insurance company said: We have a way to help you, and we are going to do it and figure out the cost in another way. No, the insurance company didn't help them. It was the State program in this case—the kind of public option that helped these kids. That part of the story has somewhat of a positive outcome. These kids are only 11. When they were 4 and 5, they didn't have that kind of an option.

This story gets worse. This is what Stacie says:

During this time, my husband had to take family medical leave so we could take turns caring for our one-year-old son and our twins at the hospital. . . .

For the 7 months my husband was out on family medical leave, he was able to maintain his employer-based insurance for us via a \$717.18 a month COBRA payment.

Let me get this straight. We are now talking about COBRA—the extension of insurance coverage for people who are hurting, laid off or unemployed. That is another government initiative enacted by Congress. I am sure there were some folks who thought let's not use government to extend health insurance. But in this case, it was helpful to this family. But it wasn't enough.

Here is what Stacie says, as she keeps going:

After spending all our savings to pay the mortgage and other basic living expenses, we had to rely on credit cards.

We have a health care system that forced Stacie Ritter, and lots of other families in America, to rely upon credit cards so they could get the health care for their daughters who have leukemia and make ends meet so they could pay the mortgage and all the other things they had to pay for for themselves and their daughters and their son. That is what this health care system has forced them to do.

This isn't unambiguous. This is exactly the result of the worse part of our health care system. This last sentence might be the most poignant. She mentions they filed bankruptcy:

And when you file bankruptcy, everything must be disclosed. We even had to hand over the kids' savings accounts that their great grandparents had given them when they were born.

That is another problem with this messed up system we have. It forced this family not only to worry about whether their daughters were going to be taken care of with leukemia, it not only said they probably had to declare bankruptcy to take care of themselves and get the care they needed, but in the course of the bankruptcy proceedings, they had to turn over savings accounts.

I don't care if it was \$1 or \$1,000 or a much higher amount. I don't care what the amount was. We should never allow a system to force two little girls with leukemia to turn over their savings accounts that their great grandparents started for them. That is how bad the system is.

I will spend lots of time complimenting doctors, hospitals, and nurses. We have a lot of good things. We have good technology. OK. I am acknowledging all that. But this system is messed up when we have this happen to one family. I don't care if it is one family or 1 million, but we know there are lots of them out there who face similar circumstances.

Some people might say you are talking about the family and all these problems. What does your bill do? It so happens the first provision in the bill—go by the table of contents and go to the page—I think page 16. The first provision of the bill talks about not having limits on lifetime coverage. If that were in effect when Stacie Ritter and her husband got the diagnosis for their daughters—if that was in effect, the following would have happened, and this is irrefutable: No. 1, they were upset, and as worried as they were about their daughters, at least they would have had the peace of mind to know they didn't have to worry about it costing too much to get them care. They would not have had to worry about this causing bankruptcy. So at least we would have given them some peace of mind and some security. Then on top of that, we would have given them the kind of care they needed, including the follow-up care.

When some people say we need to debate a little longer, 3 months or 6 months more, or let's talk about it for a couple more years—we have talked this issue to death for years. We know exactly what is wrong. This is what is wrong. That story alone is reason to pass the bill. There are a lot of other reasons, a lot of other tragedies that are preventable if we do the right thing.

We have a bill that we are going to pass, and the first provision speaks to this family's challenge.

Let me read one more letter and I will stop. I know I am over my time. We have heard a lot of discussion in the last couple of days about people whose personal tragedies bring all of us to our

senses as we get lost in the politics. I received a letter this fall that I think sums it up in a way that both Hannah's and Madeline's story does as well. This is a letter that I received from a woman in Havertown, PA, suburban Philadelphia. She says:

On September 9, 2009, my sister-in-law's cousin had to take her three-week-old son off of life support. He took two shallow breaths and passed away peacefully. He did not have to die, he did not have to be on life support, he did not even have to be in the [neonatal intensive care unit] NICU.

At 36 weeks gestation, his mother was told that she had Placenta-previa, but the insurance company and the doctor were at a tug of war on getting it covered.

This is America. Why should a doctor have to be in any tug of war about whether this mother, who is pregnant, will be covered? That should not even be a discussion. There should not have to be any discussion about that. But that is how messed up our system is.

At 39 weeks, Brandon's umbilical cord ruptured. His mother Karen was rushed to the hospital and Brandon was taken to Jefferson [hospital] in Philadelphia to undergo brain cooling treatment to return brain activity.

It was too late. After minimal return of brain activity, it was decided after 3 weeks to remove life support.

She concludes with this haunting sentence, this haunting reminder of how bad a case this is:

Who saved money here? Was it worth a child's life to save a few dollars? And I am sure 3 weeks of life support costs more than a C-section.

That is the end of her letter. So anybody who says that we have to make a couple little changes on the margins, but we have a great system that is not in need of major reform—I need only point to these two examples. That is all the information I need.

Unfortunately, we have thousands—hundreds of thousands of additional examples—literally millions of people who are denied coverage because of a preexisting condition. Sometimes because a woman has been a victim of domestic violence, that has been used as a preexisting condition in terms of whether she gets health care. So we have a messed up system.

When we allow these tragedies to happen day after day, year after year, and we have people in Washington saying: We just could not get it done, we have to debate a little longer—we have to get a bill passed. We are going to do that in the next couple of weeks. We will take whatever steps are necessary to get this legislation passed because we cannot say to this woman who wrote to me from Havertown, PA, nor can we say to these two girls and their parents—we can't walk up to Hannah and Madeline and other kids like them in the country and say we tried to get that lifetime limit matter done, but it got a little contentious.

We have to get it done, and we will get it done because we are summoned by a lot of things. But I think we are summoned by our conscience to get this done and make sure we can do everything possible—no system is perfect—to prevent these tragedies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. SANDERS. Mr. President, let me begin by thanking Senator CASEY for his consistent efforts in fighting to make sure that every American has good-quality, cost-effective health care. He has been a leader and I congratulate him.

Mr. President, I wish to touch on some of the health care issues that are out there and tell you what I think is positive in the bill we are dealing with in the Senate and tell you what I think is not so positive.

To begin with, as Senator CASEY has aptly described, we have a system which, in many ways, is disintegrating. It is an international embarrassment that in the United States of America, we remain the only Nation in the industrialized world that does not guarantee health care to all its people as a right. The result of that is, some 46 million Americans today have no health insurance. Even more are underinsured, with large copayments and deductibles.

We have some 60 million Americans today who, because of our very poor primary health care outreach network, do not have access to a doctor on a regular basis. The result of that is, as incredible as it may sound, according to a recent study at Harvard University, some 45,000 people die every single year because they do not get to a doctor when they should. As a result, by the time they walk into a doctor's office, their illness may be terminal. In addition to that, God only knows how many people end up in a hospital, at great expense to the system, because they did not get care when they should have.

Meanwhile, as Senator CASEY indicated, bankruptcy is an enormous problem because of our health care system. Close to 1 million Americans this year will be going bankrupt because of medically related bills. Furthermore, when we talk about economic growth in America, all of us understand that small businesses, medium-sized businesses are plowing an enormous amount of money into health care for their workers rather than reinvesting that money and expanding their operations and creating the kind of jobs we need as a nation in the midst of our very deep recession.

We have a major problem. At the end of the day, despite so many people uninsured, underinsured, so many people dying because they do not get health care when they need it, so many people going bankrupt, we end up spending almost twice as much per capita on health care as any other nation.

It is clear to me and I think it is clear to the vast majority of the American people that we need real health care reform. What real health care reform must be about is at least two things. No. 1, providing coverage to all Americans as a right of citizenship and, No. 2, doing that in the most cost-effective way we possibly can.

To my mind, quite frankly, there is only one way that I know of that we can provide universal, cost-effective, and comprehensive health care for all our people, and that is a Medicare-for-all, single-payer system. Very briefly, the reason for that is we are wasting about \$400 billion every single year on administrative costs, on profiteering, on advertising, on billing—all in the name of profits for the private insurance companies that have thousands and thousands of separate plans out there, creating an enormously complicated and burdensome system. With each one of their thousands of plans, if you are young and do not get sick and are healthy, they have a plan for you. If you are older and you get sick, they have another plan for you. There are 1,300 private insurance companies with thousands and thousands of plans, and to administer all of this costs hundreds and hundreds of billions of dollars.

That is money not going into doctors—we have a huge crisis in primary health care physicians—not money going into dentists. Many areas, including Vermont, have a serious dental access problem. That is money not going to nurses. We have a nursing shortage. This is money going into bureaucracy, profiteering, and salaries for the CEOs of insurance companies. It is going into inflated prices for prescription drugs in this country. As a nation, we pay the highest prices in the world for prescription drugs.

To my mind, as a nation, what we have to finally deal with is that so long as we have thousands of separate plans, each designed to make as much money as possible, we are not going to get a handle on the cost of health care in America.

In the bill we are now talking about in the Senate, we have to be clear that the projections, according to the CBO, are that, everything being equal, over a 10-year period, the cost of health care for most Americans is going to continue to soar. That is the reality. This is bad not only for individuals, not only for businesses, this is bad for our international competitive capabilities because we are starting off from the position that today we spend much more than any other country. Guess what? While this bill does a number of very good things, it is not strong on cost containment.

If we are going to try to improve cost containment—and I wonder how much we can do within the context of this particular approach to health care without being a Medicare-for-all, single-payer system—at the very least, we need a strong public option. We need that for two reasons. First of all, there is widespread mistrust of private health insurance companies for all the right reasons.

Most Americans understand that the function of a private health insurance company is not to provide health care; the function is to make as much money as possible. People do not trust private health insurance companies, and they are right in terms of their perceptions.

People are entitled to a choice. If you want to stay with your private health insurance company, great, you can do it. But as many people as possible in this country should be able to say: You know what, I am not comfortable with a private insurance company. I would rather have a Medicare-type plan.

Poll after poll suggests that the American people want that public option. That is point No. 1, freedom of choice. People should have that choice. If they do not want it, that is fine.

Point No. 2 may be even more important, if we are going to get a handle on exploding health care costs, somebody is going to have to rein in the private insurance companies whose only function in life is to make as much money as they possibly can. We need a non-profit, government-run public plan to do that. If we do not have that in this bill, I am not sure how we are going to get any handle on cost containment.

I will fight to make sure we have as strong a public option as we possibly can. As I have said publicly many times, my vote for this legislation is not at all certain. I have a lot of problems with this bill. We have to have at least, among other things, a strong public option.

Let me tell my colleagues something else I think we have to address in this bill. As I mentioned a moment ago, we have a disaster in terms of primary health care in America. Some 60 million Americans are finding it difficult to get to a doctor on a regular basis, and that is dumb in terms of the health and well-being of our people. It is also dumb in terms of trying to control health care costs.

If somebody does not have a doctor they can go to when they get sick, where do they end up? They end up in the emergency room, and everybody knows the emergency room, by far, is the most expensive form of primary health care. Yet millions of people have no other options. They end up in an emergency room. If they have a bad cold, Medicaid may pay \$500 to \$600 for their visit to the emergency room. That is totally absurd.

Furthermore, if you have a primary health care physician, that person can work with you on disease prevention—helping you get off cigarette smoking or helping you with alcohol, a drug problem, a whole myriad of issues in terms of good prevention, good nutrition. That we have a disaster in primary health care which is driving people to the ER makes no sense at all.

As I mentioned the other day, there is a provision in this legislation in the Senate which authorizes a very significant expansion of federally qualified community health centers which, in a nonpartisan way, a bipartisan way is widely supported by, I suspect, almost everybody in the Senate and in the House as well.

These community health centers today allow 20 million people to access not only good, quality primary health care but dental care, which is a huge

issue all over this country, mental health counseling, a very big issue, and low-cost prescription drugs.

The problem is, while the community health centers today do an excellent job, there are not enough of them. So in this legislation, we have greatly expanded community health centers. If we as a Congress are talking about bringing 13, 14, 15 million more people into Medicaid, I am not quite sure how a struggling Medicaid Program is going to accommodate those people, unless we provide the facilities and the medical personnel to treat them.

We need this. We need to expand primary health care. Community health centers are the most cost-effective way I know how to do that. There are studies that suggest providing that primary care, keeping people out of the emergency room, keeping them out of the hospital because they have gotten sicker than they should have gotten, we can, in fact, pay for these community health centers over a period of years by simply saving money.

In the Senate, we have very good language authorizing an expansion. In the House, they have similar language, except in the House they have a trust fund which actually pays for this. I am going to do my best to make sure we adopt the House language, which pays for, through a trust fund, a substantial increase in community health centers and, in addition, a very significant expansion of the National Health Service Corps, which is a Federal program which provides debt forgiveness and scholarships for medical students who are prepared to serve in medically underserved areas in primary health care.

We desperately need more primary health care physicians, nurses, dentists. That is what the National Health Service Corps does. My hope is the Senate will adopt the House provision to greatly expand the National Health Service Corps and the Health Service programs. That is an issue that is very important to me.

Let me touch on another issue, which is clearly going to be contentious; that is, at the end of the day, we are going to be spending on health care somewhere around \$800 billion to \$1 trillion. The American people want to know a couple of things. They want to know: Is this going to raise our national deficit? What CBO tells us is, no, it will not. More money is going to come in than goes out. There will be savings incorporated in the legislation, and that is a good thing. We have a \$12 trillion national debt, and we do not want to add to that.

But people are also asking how are you going to raise the money? How are you going to pay for this? Where does the \$800 billion to \$1 trillion come from? Here is where we have a bit of differences of opinion.

In the House, I think they have, once again, done the right thing. What the House has done is raise \$460 billion, with a surcharge on the top three-tenths of 1 percent of taxpayers. These

are the wealthiest people in this country. What the House has said, quite appropriately, is that at a time when the gap between the rich and everybody else is growing wider and at a time when the top 1 percent earn more income than the bottom 50 percent, it is appropriate, especially after all of President Bush's tax breaks, to ask the wealthy to start paying their fair share of taxes so we can provide health insurance to tens of millions of Americans. That, in my view, is exactly the right way to go.

Unfortunately, in the Senate, we have not done that. What we have chosen to do in the Senate is to raise about—I do not know the exact number—but we have chosen to impose an excise tax of 40 percent on so-called Cadillac plans. The problem is, given the substantial increase in health care costs in this country, a Cadillac plan today in 5 or 10 years may be a junk car plan.

I believe with a struggling middle class, with people desperately trying to hold onto their standard of living, the last thing the Senate wants to do is impose a tax on millions and millions of working people who have fought hard to get a halfway decent health care plan.

Let me very briefly read from a fact sheet that came from the Communications Workers of America. CWA is one of the largest unions in this country. Similar to almost every union, they are strongly opposed to this excise tax on health care benefits. This is what they say. I read right from it. This is a document from the CWA:

The U.S. Senate will soon vote on legislation that would tax CWA-negotiated employer health plans. The tax will be passed directly onto working families. To avoid the tax, employers will try to significantly cut benefits for active workers and pre-Medicare retirees.

How the House Benefits Tax Works.

A 40-percent excise tax would be assessed on the value of health care plans exceeding \$23,000 for a family and \$8,500 for an individual starting in 2013. (Levels are higher for pre-Medicare retiree plans and high-risk industry plans—\$26,000 and \$9,850.)

And here is an important point. Because while people may not have to pay this tax in a couple of years, with health care costs soaring, they will have to pay this tax in the reasonably near future.

Quoting from the CWA document:

These "thresholds" would increase at the rate of general inflation, plus 1 percentage point, or 3 percent. This is well below the medical inflation rate (4 percent) and about half the rate (6 percent) at which employer and union plan costs have been increasing.

In other words, the cost of health care is rising a lot faster than inflation, which today is almost zero. It may actually be below zero, the point being that in a number of years, so-called Cadillac plans are going to reach the threshold upon which middle-class workers are going to be forced to pay a lot in taxes.

Let me go back to the CWA now. They write:

Health Benefits Tax Will Hit CWA—

And they are talking about many union workers here.

—CWA-negotiated Plans Hard and Result in Deep Cuts. In 40 of 43 states examined over 10 years (2013–2022) the average excise taxes assessed on each worker in CWA's most popular plans will be: \$13,300 per active worker in the family plan.

That is for a 10-year period, \$13,300.

\$5,800 per active single worker, \$13,600 for pre-Medicare retiree in the family plan, and \$4,400 for pre-Medicare retiree in the single plan.

The bottom line is that the middle class in this country is struggling. We are in the midst of the most severe recession since the Great Depression of the 1930s. People are working longer hours for lower wages. The middle class is on the verge of collapse. The Senate should not be imposing an additional tax on middle-class workers. The House got it right; the Senate got it wrong, and I intend to offer an amendment to take out this tax and replace it with a progressive tax similar to what exists in the House.

Let me conclude by simply saying this: I understand that the leadership wants to move this bill forward as quickly as possible. I understand that. But in my view, we have a lot of work in front of us to improve this plan. Among many other things—many other things—and I know other Members have different ideas—at the very least, States in this country—individual States—if they so choose, should be able to develop a single-payer plan for their States. Because at the end of the day, in my view, the only way we are going to provide comprehensive, cost-effective, universal care is through a single payer.

I know some people are saying: Well, we are dealing with health care, we are not going to be back for a long time. If this bill were passed tomorrow, trust me, we would be back in a few years, because health care costs are going to continue to soar. Winston Churchill once said: "The American people always do the right thing when they have no other option." And I think that is what we are looking at right now. We are running out of options.

What we have put together is an enormously complicated patchwork piece of legislation. It is going to help a lot of people. It involves insurance reform, which is absolutely right. We have a lot of money into disease prevention, which we should have. There are a lot of very good things in this bill. But it is not going to solve, in my view, the health care crisis. Costs are going to soar. If we don't have the courage as a body to take on the insurance companies, to take on the drug companies, at the very least let us give States—whether it is Vermont, Pennsylvania, California, or other States—the right to become a model for America; to provide health care to all people in a cost-effective way through a Medicare-for-all, single-payer system. We have to do that.

The other thing we have to do, in my view, is to get rid of this tax on the middle class by taxing health care benefits. Mr. President, you will recall that a year ago we were in a highly controversial and difficult Presidential campaign. One candidate, who happened to have lost that election—a Member of the Senate, Senator MCCAIN—came up with a plan that was exactly—or very close to it—to what we are talking about today. Then-Senator Barack Obama, who won that election, came up with a different plan, because he said that wasn't a good idea. Well, how do you think millions of American workers are going to feel when they say: Wait a second, the guy who won told me he was against taxing health care plans, and now we are adopting the program of the guy who lost. How do the American people who voted in that election have faith in their elected officials if we do exactly what we said we would not do?

So I believe we have to move toward a progressive way of funding this health care plan. As I stand here right now, this plan has a lot of good stuff in it, but there are a lot of problems in it. I very much look forward to the opportunity to be able to offer a number of amendments to strengthen this bill. It is very important to the people of Vermont and to people all over this country that not only I but the Presiding Officer and other Members have a right to offer amendments. Because if this bill gets whizzed right through, and is not as strong as it possibly can be, I think we will not have done the job we need to do.

Mr. President, with that, I yield the floor.

Mr. KOHL. Mr. President, as chairman of the Special Committee on Aging, the plight of vulnerable seniors is a subject of great concern to me. The committee is charged with uncovering problems that endanger the health and welfare of older adults and developing policy to prevent seniors from becoming victims of fraudulent scams and abuse.

During this Congress, I have been fortunate to be joined by my colleagues, Senators LINCOLN and HATCH and STABENOW, in advancing policy to reduce elder abuse. The Senate health care reform bill now includes both the Elder Justice Act and the Patient Safety and Abuse Prevention Act, and we will do our utmost to see that they become law.

Today I am pleased to continue the effort to protect America's vulnerable seniors by introducing an amendment that combines two very valuable bills, the Elder Abuse Victims Act and the National Silver Alert Act. Both have been passed by the House of Representatives.

Elder abuse is a sad scourge on our society, often hidden from sight by the victims themselves. Even so, experts conservatively estimate that as many as 2 million Americans age 65 and older have been injured, exploited or other-

wise mistreated by someone on whom they depend for care or protection.

As Federal policymakers, it is time that we step forward and tackle this challenge with dedicated efforts and more vigorous programs that will make fighting elder abuse as high a priority as ongoing efforts to counter child abuse.

It is in this spirit that I am offering an amendment to give the Department of Justice a roadmap for how to establish programs to bolster the frontline responses of state and local prosecutors, aid victims, and build a robust infrastructure for identifying and addressing elder abuse far more effectively than we do today.

We need to provide assistance to our courts, which would benefit from having access to designated staff that boast particular expertise in elder abuse. Specialized protocols may be required where victims are unable to testify on their own behalf, due to cognitive impairments or poor physical health. And there is a great need for specialized knowledge to support successful prosecutions and enhance the development of case law. Today, many state elder abuse statutes lack adequate provisions to encourage wide reporting of abuse and exploitation, more thorough investigations and greater prosecution of abuse cases.

For the victims of elder abuse, many of whom are physically frail and very frightened, we must do much more. First and foremost, we must be more responsive. Not too long ago, it was difficult to even get an abuse case investigated. While that is starting to change, we have much work ahead. For example, sometimes emergency interventions are necessary, particularly if the older person is being harmed at the hands of family members or trusted "friends." It may be necessary to remove the older adult from his or her home to a temporary safe haven. To do this, we must build a much more robust system of support.

And there is more we must do to assist vulnerable seniors who may not be abused, but who are nonetheless vulnerable because they suffer from cognitive impairment. As the prevalence of dementia rises in our aging society, we have a special responsibility to ensure that those who "go missing" from home are returned promptly and safely. This is the purpose of the second part of the amendment, which proposes to create a national program to coordinate State Silver Alert systems.

The Amber Alert system, on which the Silver Alert Act is modeled, was created as a Federal program to rapidly filter reported information on missing children and transmit relevant details to law enforcement authorities and the public as quickly as possible. Using the same infrastructure as Amber Alerts, 11 States have already responded to the problem of missing seniors by establishing Silver Alert systems at very little additional cost. These programs have created public no-

tification systems triggered by the report of a missing senior. Postings on highways, radio, television, and other forms of media broadcast information about the missing senior to assist in locating and returning the senior safely home. Now we have an opportunity to finish the job and create Silver Alert programs across the country.

Both of the provisions in this amendment are strongly supported by the Elder Justice Coalition. I ask my colleagues to support this amendment, and by doing so to markedly reduce the risk of harm to our most vulnerable citizens.

Mr. SANDERS. Mr. President, it appears I am going to be closing tonight.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

#### MORNING BUSINESS

Mr. SANDERS. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

#### TRIBUTE TO VIDA CHAN LIN

Mr. REID. Mr. President, I rise today to honor Vida Chan Lin. The Las Vegas Asian Chamber of Commerce recently named Vida Chan Lin as their first female president. For many years, Lin has been an advocate for Nevada's Asian Pacific Islander American, APIA, community. Her early exposure to the complexities of business and the APIA community has cultivated the passion and talent necessary for success.

Vida Chan Lin moved to Las Vegas in 1994 and began developing her career as an insurance sales representative. Within a few years, Lin pursued her entrepreneurial interests and launched an insurance agency named V&J Insurance. The company was committed to providing outstanding service and education to Asian and minority communities in Nevada. Vida Chan Lin's success continued when she was named vice president after a merger between V&J Insurance and Western Risk Insurance.

Vida Chan Lin's continued involvement and dedication with supporting local community and business organizations resulted in a significant partnership that benefits families and businesses across Nevada. Lin has also advanced local business endeavors through her work with the Asian Chamber of Commerce, ACC, and the OCA Las Vegas Chapter. During her tenure in ACC, she helped develop annual events such as the Chinese New Year Community Achievement Awards Dinner, Bill Endow Golf Tournament, and Asian Business Night. Her help with the OCA Las Vegas Chapter resulted in two national events to be held in Las Vegas for the first time—the

OCA National Convention and the National Asian Pacific American Corporate Achievement Awards.

Being a leader in the Asian Pacific Islander American community has provided Vida Chan Lin an opportunity to affect younger generations. Her positive attitude and passion for APIA issues brought forth an inspiration within our youth to provide for their communities. Lin promotes and ensures that the voice of APIA youth is heard. She continues to dedicate time for students involved in the OCA Las Vegas Chapter and ACC by engaging them in entrepreneurial development opportunities such as the Clark County Summer Business Institute.

As she continues to advance her career and charitable interests, Vida continues to give great care to her family. Las Vegas is better as a place because of dedicated people like Vida Chan Lin. Vida's dynamic ambition reminds me of a quote from one of this country's greatest Presidents. Teddy Roosevelt once said:

The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly; who errs and comes short again and again; because there is not effort without error and shortcomings; but who actually strive to do the deed; who knows the great enthusiasm, the great devotion, who spends himself in a worthy cause, who at the best knows in the end the triumph of high achievement and who at the worst, if he fails, at least he fails while daring greatly. So that his place shall never be with those cold timid souls who know neither victory nor defeat.

Vida is not a timid soul. She strives for success with her family, career, and community.

I know that Vida Chan Lin and the Las Vegas Asian Chamber of Commerce have a bright and blessed future. I congratulate Vida on being the first woman to lead the Asian Las Vegas Chamber of Commerce.

#### REMEMBERING ALBERT E. DIX

Mr. McCONNELL. Mr. President, all of the Commonwealth of Kentucky has suffered a great loss with the recent death of Albert E. Dix. A fourth-generation journalist, Al Dix moved to Frankfort, Kentucky's State capital, to become publisher of *The State Journal* in 1962, a post he would keep until his retirement in 1996. Known for being a mentor to aspiring journalists, Al Dix helped train scores of individuals who went on to work at papers with much larger circulations. But he was more than just one of Kentucky's finest journalists. As one of his former press foremen put it, "He treated all employees really well, just like they were his family. He was a really good person all around."

Indeed, Al Dix leaves behind a legacy as not only a superb publisher but as a pillar of his community. While I could say much more about my friend Al Dix, I think it appropriate for me to share with my colleagues a recent account of

Al's life, which was published by *The State Journal* on December 3, 2009. I ask unanimous consent that the full article be printed in the RECORD.

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

[From the *State-Journal*, Dec. 2, 2009]

FORMER PUBLISHER AL DIX REMEMBERED AS CARING LEADER

(By Charlie Pearl)

Journalists, bankers, politicians, educators and others today paid tribute to Al Dix as a sensitive and caring publisher who was dedicated to improving the community but kept his good works private.

Dix died at his home in Frankfort Tuesday morning of pancreatic cancer. He was 80. Services will be 2 p.m. Friday at South Frankfort Presbyterian Church with visitation at noon. Burial will follow at Frankfort Cemetery.

Richard Wilson, who retired from *The (Louisville) Courier-Journal* as its higher education reporter, got his first job in newspapers with *The State Journal* under Dix in 1963 and 1964.

"That helped me immensely during a nearly 40-year career in journalism," Wilson said. "Much of the reason for that was Al, who was unquestionably a reporter's publisher. He was encouraging, respected quality work and openly shared his enthusiasm for its appearance in the newspaper."

"While he may have held strong views on many subjects, he never permitted them to permeate *The State Journal's* news columns and he respected those who believed otherwise. He also frequently took a personal interest in his employees and their well-being, both professionally and personally."

Bruce Brooks, retired executive vice president at Farmers Bank, said he always considered Dix "a dear friend. He was a little bit of a mentor to me."

"He was always willing to be a listening board for any situation. He was free with his advice and usually it was pretty sound and analytical."

Brooks said Dix was master of ceremonies at various functions, "and was really, really skilled at it. And he always had an open checkbook for a worthy cause. He would walk the walk and talk the talk."

Former City Commissioner Pat Layton said Dix encouraged her to start her real estate career.

"He had a lot of insight of what was going on in the community," Layton said. "It wasn't because he was publisher of a newspaper but because he really loved his community."

"He was truly a leader. But a lot of people didn't know about the many things he did for Frankfort because he was very private about it. He was a silent supporter. When there was a need, he was there and stepped right up front. He was a special guy."

State Sen. Julian Carroll, who was governor while Dix was publisher, said, "Al was a great community-minded leader. Although he was a Republican and I'm a Democrat, he was always very nice and cordial to me. I considered him to be one of our outstanding citizens."

Bob Roach, a retired school teacher and former city commissioner and county judge-executive, said Dix "was certainly interested in young people and education, and he believed in excellence. He was a prince of a fellow."

While teaching at Franklin County High School, Roach said he took groups of students to Washington, D.C., for 25 years to participate in a North American Invitational Model United Nations program, "and we could always count on him for a donation."

By sponsoring an annual State Journal All-Academic Banquet, Dix encouraged students to excel in the classroom, Roach said, "and he encouraged teachers by recognizing them as well."

Dix could also be a confidant, Roach said. "You could go talk to him about an issue and you knew it would always be in confidence," Roach said. "And I knew his advice would be on target."

Attorney Bill Kirkland, a former Paul Sawyer Public Library president, said Dix was on a special gifts committee during fundraising for the new library and he came faithfully to every meeting.

"He had numerous contacts in the community and personally added immeasurably to the quality of the library through the gifts he solicited."

"He was a person of intellect, humor, good personality and good judgment. There was never a kinder soul and more generous person in the community."

Kirkland said their friendship spanned four decades.

"About 40 years ago, we played one-wall handball at the old YMCA on Bridge Street. I knew him first through his connection with South Frankfort Presbyterian Church, and through a few Republican endeavors. He certainly was a conservative after my own heart."

"He had extraordinary compassion and was interested in literacy, education, good government and ethical behavior."

Bruce Dungan, retired president of Farmers Capital Bank Corporation, said when Dix first came to Frankfort from Ohio, "I could tell he was here to be a friend of Frankfort. He was very thoughtful of people."

"He was here to help people, charities, government and his church. He worked so hard at charities. He would call me and say what I had given last year, and then say, 'Don't you think you ought to raise it a little this time?'"

"If it hadn't been for Al, the YMCA (on Broadway) may never have happened. He kept pushing everybody. He did whatever he could to improve Frankfort. He was one of the greatest guys in Frankfort that I know of. We're going to miss him. I sure will."

Irvine Gershman, a retired downtown merchant, said Dix "coming here from Ohio was probably one of the best things to happen to Frankfort. He was always willing to do things for other people."

"He and his family have contributed so much to this community. When I would call on him for a little help (to various charities), he would just say, 'How much do you need?'"

Gershman's wife, Priscilla, said Dix "was a precious jewel. He will be sorely missed by everyone."

Russ McClure, a former vice president of Morehead State University, said he was "under the gun a lot of times" while serving as Finance Cabinet secretary to Carroll and assistant budget director to Bert Combs when they were governors.

"One thing I could always count on was Al being straight up and fair," McClure said. "He was always straightforward with his questions and always accurate in his reporting of my answers and the facts."

The Rev. John Hunt, retired pastor of South Frankfort Presbyterian Church, said he has fond memories of getting to cover one of the launches of the Gemini space program in the early 1960s for *The State Journal* because of Dix.

"He knew of my interest in science and he credentialed me," Hunt recalled.

When Hunt got to Cape Canaveral, bad weather caused the flight to be postponed, so he figured he would have to miss the experience because he would need to get back to Frankfort for Sunday church services.

But Dix encouraged him to stay in Florida, saying he would give the sermon on Sunday, Hunt said.

"He filled the pulpit for me and did an excellent job," Hunt said. "He got rave reviews and supplied the pulpit on my absences after that. I was about ready to swap places with him."

Scottie Willard, who retired in September as press foreman after 44 years at The State Journal, remembers when Dix became publisher in 1962.

"He made a lot of improvements as far as press equipment when he took over," Willard said. "He treated all employees really well, just like they were his family. He was a really good person all around."

Ronnie Martin, retired composing foreman who worked at the newspaper 43 years, agrees.

"He was super to work for," Martin said. "He gave me all sorts of opportunities and challenges at the same time, but they all worked out. He was a great guy. He treated everybody fairly."

Ann Maenza, Dix's daughter, now publisher of The State Journal, said her father "never cut corners. He always made sure things were done right. He was old school, fair and honest."

Amy Dix Rock, senior director of regulatory and scientific affairs at Cumberland Pharmaceuticals Inc. in Nashville, Tenn., said her father was "always thinking of others. We don't know how many things he's done for others because he didn't talk about it."

"That's the way he was. He was soft-spoken but when he did speak you listened."

Al Smith, who rose to prominence in the state as a weekly newspaper publisher and as the longtime host of KET's "Comment on Kentucky," said Dix was a newspaper publisher of the old school, "but the opposite of the domineering egotistic bosses who bullied employees and squeezed the news to match their biases."

"Old school" means that we always knew that with Al at The State Journal, it was like the grocery slogan of years ago, "the owner is in the store." He didn't have to call a distant headquarters to know what to say or do.

"He had strong views, conservative Republican in a 'company town' (state government) of readers who are mostly Democratic, but he ran the paper on principles of fairness in the news columns and gave his editorial writers, who were mostly more liberal than he, free rein on the opinion page."

Smith noted how The State Journal under Dix supported a constitutional amendment that overhauled the state's judicial system and created what is today the Supreme Court. Smith also noted the newspaper's spotlight on corruption in government and how Dix shunned personal publicity.

"Once I wrote him a private note about something very generous he had done to help someone in trouble," Smith said. "I heard nary a word in reply. But I didn't expect it. I am sure he was embarrassed that I even knew."

Born Aug. 18, 1929, in Ravenna, Ohio, Albert E. Dix majored in political science and was a 1951 graduate of Denison University in Granville, Ohio.

He served in the U.S. Army Intelligence from 1953-1955.

A fourth-generation journalist, Dix first worked at The Times-Leader in Bellaire, Ohio, where his father was publisher. He moved to Frankfort in October 1962 to become publisher of The State Journal. He retired in 1996 as publisher and president of Wooster Republican Printing Co., the parent company of The State Journal, which now owns seven newspapers.

The Kentucky Book Fair was founded by The State Journal in 1981.

Dix also was a member of the board of directors of First Capital Bank of Kentucky, the Frankfort/Franklin County Industrial Development Authority and the local Kiwanis Club; and served two terms as chairman of the American Saddlebred Museum at the Kentucky Horse Park in Lexington.

He loved fishing and making fishing rods, electric trains and saddlebred horses.

Other survivors include his wife of 56 years, Edna Dix; a son, Troy Dix, publisher of the Ashland Times-Gazette in Ohio; and four grandchildren, Evan, Stewart and Melissa Dix and Lauren Maenza.

## CUBA

Mr. KERRY. Mr. President, I rise as a cosponsor for S. 428, the Freedom to Travel to Cuba Act.

It is time we brought our strengths to bear—our people, our vision, our energy—to help the Cuban people shape the future direction of Cuba and to fix a policy that has manifestly failed. For America to act as the great power we are, with confidence in our values and vision, we need a Cuba policy that looks forward.

The truth is, we have reached out to countries where our wounds were far deeper, and far more recent. When JOHN MCCAIN and I led the efforts to unfreeze our relationship with Vietnam, we said: "let's be honest . . . the Cold War is over. All the American trade embargo is doing is keeping Vietnam poor and thus encouraging a flood of refugees."

For nearly 20 years after the fall of Saigon, the Vietnam war took a less bloody but equally hostile form. The U.S. and Vietnam had no diplomatic relations. Vietnamese assets were frozen. Trade was embargoed. But in 1995 the United States normalized relations with Vietnam. The Cold War had ended, and we even signed a trade deal with a country where 58,000 Americans had given their lives.

The results? A Vietnam that is less isolated, more market-oriented, and, yes, freer—though it has miles to go.

And yet, when it comes to Cuba, a small, impoverished island 90 miles off the shores of Florida, we maintain a policy of embargo—motivated by past grievance, not present realities and future dreams. Fidel Castro has stepped aside from day-to-day government, there is a new American President, and Cuban-Americans increasingly want broad, far-reaching interaction across the Florida Straits. Times are changing, and we cannot live in the past.

Forty-seven years ago, I was in my first semester of college when Soviet missiles, deployed in Cuba, threatened to set the world on fire. No one who lived through those thirteen harrowing days in October will ever forget them. Certainly, the threat from Cuba was real.

It is true that we continue to disapprove of Cuba's dismal human rights record and palpable lack of freedom. And it is also true that, over 50 years, the embargo can claim some successes.

For example, it can be reasonably argued that U.S. pressure contributed to Cuba's decision to cease its military adventurism in Africa and its support for the violent insurgencies that ripped apart Central America in the 1980s.

But on the two most important questions, the verdict is decisive:

First, did this policy fulfill its oft-stated purpose of overthrowing the Castro regime? Fidel Castro outlasted nine American Presidents, from Eisenhower to Clinton, and retired only for reasons of health during the tenth. When he passed on the reins to his brother, Fidel joined Omar Bongo of Gabon and Libya's Colonel Qaddafi as one of the world's longest-serving head of states.

Second, have the benefits of our policy outweighed the costs? It is hard to argue they have. The embargo has cost Cubans access to our markets, and for many years to our food and medicine—with little progress to show. But it has cost us as well. It has limited the influence of our people and our democracy. What's more, this fall's U.N. vote condemning America's embargo showed yet again: Cuba is not the only country isolated by our policy. The vote against our policy was 187 to 3. All of our major allies voted against us, and one of the two voting with us itself routinely trades with Cuba.

Is it morally satisfying to sanction a government whose human rights practices we abhor and whose political system rejects many of our values? Sure. And helping Cubans to live in democracy and liberty absolutely remains a goal of American policy. But for 47 years now, we have endorsed an embargo in the name of democracy that produced no democracy!

In fact, our rhetoric and policies have actually helped to consolidate the Cuban government. We have provided the Castro regime with an all-purpose—if exaggerated—excuse to draw attention away from its many shortcomings, including its shamelessly flawed economic model. For too many Cubans, our threats have legitimized Castro's outsized nationalism and repression of opponents. Our posture has played to his strengths.

At the same time, we have not brought our strengths to bear—our people, our vision, our energy, our opportunities. It is time for America to act as the great power it is—with greatness built on confidence in our values and vision.

Of course, the greatest cost of our policy has been borne by the Cuban people themselves. José Martí, Cuba's great "Apostle" and man of letters, once said: "Everything that divides men, everything that classifies, separates or shuts off men, is a sin against humanity." More than 70 percent of Cuba's 11½ million people have lived their entire lives in this stalemate. A Cuban boy or girl of 10 when Fidel Castro drove victorious into Havana is 60 years old today. His whole life has been spent deprived of basic freedoms but

also deprived—in accordance with U.S. policies except during brief periods—of interaction with America's people.

We must have the courage to admit the need for a new approach. President Kennedy, who instituted sanctions against Cuba, had by mid-1963 set in motion secret contacts aimed at normalizing relations. Ford and Carter, too, looked for ways out of the box. George H.W. Bush cooperated with Cuba on the Angola peace accord, and his administration even dangled a promise of improved ties with America. Each initiative failed for a different reason, but all were grounded in the same recognition: there must be a better way forward.

Fortunately, we know there is a different strategy that can succeed. The Clinton administration worked to refocus our policy around what matters: on the Cuban people, not the Castro brothers; on the future, not the past; and on America's long-term national interests, not the political expediencies of a given moment.

The Clinton administration promoted people-to-people relations “unilaterally”—without conditions on Havana. We worked to improve bilateral cooperation on issues like migration and combating drug trafficking, which were clearly in our national interest. Family travel in both directions quickly skyrocketed. And tens of thousands of Americans from across society—church members, academics and students, medical professionals, athletes, journalists, and more—were permitted to interact with their Cuban counterparts.

Those policies sent a clear and effective message to the Cuban people: the United States is not who your leaders say we are. Our problem is not now, nor has it ever been, with the Cuban people. We completely changed the dynamic: A synagogue with holes in its roof so big that birds flew around the sanctuary has been repaired with funds and materials from American supporters. Environmentalists worked together to save species and protect our shared environment. The children who received bats and balls—and moral support—from Baltimore Orioles players visiting Cuba for an exhibition game will never forget the gesture of American generosity.

And guess what. Across the board, Cubans seeking a better future for their country have said that nothing energized civil society in Cuba more than contact with U.S. civil society. Even Cuba's human rights and democracy activists benefitted immeasurably from the contact.

Unfortunately, the Bush administration shut down most forms of contact and dramatically reduced our interactions to a tightly regulated, government controlled trickle. They tightened licensing procedures, reduced transparency, and put government in the people's way in what amounted to a unilateral suspension of Americans' ability to help Cubans shape their fu-

ture. People-to-people relations were made secretive, filtered, and for narrow objectives. That is the opposite of pro-democracy.

Regrettably, that was the record of the Bush administration: an enormous step backwards. Now it's up to the Obama administration to craft a Cuba policy that moves us forward.

In May 2008, Barack Obama said on the Presidential campaign trail that it was “time for a new strategy.” While he wasn't ready to give up the embargo as a source of leverage, he did declare at the Summit of the Americas: “The United States seeks a new beginning with Cuba,” and announced that he was “prepared to have [the] Administration engage with the Cuban government on a wide range of issues.”

As promised, the Obama administration has expanded licenses for Cuban-Americans—albeit only Cuban-Americans—to travel to Cuba. Controls on family remittances, gift parcels, and certain transactions with telecommunications companies were loosened as well. Mid-level talks about immigration matters and postal relations have resumed. And we've turned off an Orwellian electronic billboard flashing political messages from our Interests Section in Havana.

These are positive steps, but they are only a start. So what comes next?

At a minimum, the administration should use the authorities that it has to reinvigorate people-to-people relations—to unleash the energy of the American people who want to help Cubans build their future. The policy worked in the past and enjoyed wide support in both countries.

When announcing expanded family travel, the President said, “There are no better ambassadors for freedom than Cuban-Americans.” But I think it's also fair to say that there are excellent ambassadors for freedom among the 299 million other Americans—religious faithful, teachers and students, environmentalists, scholars, doctors and nurses, political scientists, and artists—whose challenging minds, economic success, love for democracy, and advocacy of solid American values make them proud ambassadors as well.

The New York Philharmonic and its board of directors have been brilliant representatives of America on trips to North Korea, Vietnam and around the world. I don't understand why the administration recently blocked their proposed trip to Cuba. What are we afraid of?

Second, as we reinvigorate people-to-people diplomacy, the administration should review the programs that the Bush administration funded generously to substitute for it.

The Senate Foreign Relations Committee is already undertaking an investigation into the need to reform Radio and TV Martí—programming beamed into Cuba at a cost of \$35 million a year. Many Cubans call TV Martí “La TV que no se ve” because it has never, in 18 years of broadcast, had a signifi-

cant audience in Cuba. Report after report has documented that the Martí services are hindered by bad management, weak professional tradecraft, and serious politicization. We are looking at whether its business model—as a “surrogate service” exempt from many Voice of America standards and regulations—has failed, and whether the TV service should be closed entirely and radio should be integrated into the high-quality VOA services. We ought to be especially concerned that human rights activists in Cuba a key bellwether audience are unanimous in their view that the Martí brand must be repaired.

Meanwhile, USAID's civil-society programs, totaling \$45 million in 2008, have noble objectives, but we need to examine whether we're achieving any of them. The Bush administration changed the program's focus from supporting the Cuban people to accelerating regime change, and the fact that some of our grantees have extravagantly high overheads has raised concerns about where all the money is going. It is also fair to ask whether these programs even work.

Bush's refocus on regime change made it difficult for Cubans outside declared antiregime groups to accept the informational materials or assistance offered—even if they had a burning desire for it. Our interests section used to distribute tens of thousands of books a year to Cubans across the political spectrum and the books could be seen, well-worn, in government and Communist party think tanks. Today, politicization has reduced the flow of information to many of the very same people eager to steer Cuba toward a better future.

The Foreign Relations Committee has begun a review of these programs. It is in the administration's interest to take the lead in overhauling them.

Finally, as I mentioned at the outset, I want to address legislation that will go even farther toward fixing our Cuba policy. S. 428, the Freedom to Travel to Cuba Act, does not lift the embargo or normalize relations. It merely stops our government from regulating or prohibiting travel to or from Cuba by U.S. citizens or legal residents, except in certain obviously inappropriate circumstances.

The Freedom to Travel to Cuba Act has strong support in Congress—33 sponsors in the Senate and 180 cosponsors for similar legislation in the House. I cosponsored similar legislation in the past, and I am proud to do so again. We are talking about restoring a fundamental American right—the right to travel—that is denied to Americans nowhere else in the world. Americans who can get a visa are free to travel to Iran, Iraq, Sudan, and even North Korea, and it makes no sense to deny them the right to travel to a poor island near Florida. There is a certain irony in the fact that Americans have to apply for licenses and wait, with little or no feedback, to travel to a country that we criticize for denying its

citizens the right to travel. The current ban on travel contravenes the spirit of the Universal Declaration of Human Rights' statement that "everyone has the right to leave any country, including his own, and to return to his country."

Free travel also makes for good policy inside Cuba. Visits from Americans would have the same positive effects as people-to-people exchanges, but on a larger scale. Visiting Europeans and Canadians have already increased the flow of information and hard currency to ordinary Cubans, with a significant impact on the country. Cuba's economic model, for sure, remains profoundly flawed, and human rights conditions remain dismal. But the hard-currency sectors of the Cuban economy have significantly altered workers' dependence on the regime, introduced material incentives that are changing economic culture, and raised expectations, if not demands, for greater improvements in the future. After years of Cuban government propaganda, Americans are even better positioned than Europeans and Canadians to be catalysts of change. We can do more if we let them.

That is one reason why all of Cuba's major pro-democracy groups support free travel. Freedom House, Human Rights Watch, and other groups critical of Cuba's government agree. Studies of change in Eastern and Central Europe show a direct correlation between contact with the outside world and the peacefulness and durability of democratic transitions.

This is a policy whose time has come. Numerous polls of Americans—of Cuban origin and otherwise—show strong support. Non-Cuban-Americans have long supported easing restrictions. But here is what is surprising: one recent poll found that 59 percent of Cuban-Americans—the group most widely thought to oppose a change in policy—actually support allowing all American citizens to travel to Cuba. As the proportion of Cuban Americans who arrived after 1980 increases, support for free travel is only growing. In fact, even many Cuban émigrés 65 years and older, once passionately opposed to it, now favor free travel. This is a sea change in the attitudes of Cuban-Americans, and we should not ignore it.

Change is in the air—in Havana, in Washington, and in major Cuban-American communities. I don't personally hold high hopes that the transfer of power from Fidel to Raúl Castro and to the next generation of hand-picked loyalists portends rapid change, but it is obvious that the Cuba of today is not the Cuba of the 60s or even the 90s, and that our policy should not be stuck in time either. Cubans are searching for models for the future, and our economic system and democratic ideals appeal to them.

In September, when the Colombian rock star Juanes came to Havana, by some estimates as many as a million

people came to hear the concert. From the stage, he looked out at the Cuban people and started a simple chant: *Una Sola Familia Cubana*. The crowd roared approval at the thought of ending the conflict between Cubans across the Florida Straits.

There is a hunger out there among the Cuban people. America should capitalize on it. They want contact with their own families, and they want contact with American people and American ideas.

There is no other country in the world to which we have closed our lives as long as we have to Cuba. The Berlin Wall fell 20 years ago, but the wall separating Americans and Cubans has yet to come down.

We have a choice to ignore change and resist it or to mold it and channel it into a new set of policies. After 50 years of trying to isolate and destroy, it's time to try working with the Cuban people and making a new future together.

#### REMEMBERING SENATOR PAULA HAWKINS

Mr. HATCH. Mr. President, I rise today to speak about the passing of Paula Hawkins, a former colleague of mine in the U.S. Senate and a very dear and close personal friend whose service to the Nation and her home State of Florida will endure for generations in the heads and hearts of her posterity, friends and legions of admirers.

In the ranks of those who greatly admire and will dearly miss Paula, I stand front and center today to salute this extraordinary woman for her accomplishments, outstanding public service, wonderful family and exemplary life. As I do so, I am humbled by the magnitude of the task. It is not easy to find the right words to do justice to such a unique and choice individual.

That said, I guess the first thing that comes to mind about Paula Hawkins is that, true to her Utah Mormon heritage, she was a pioneer—a real trailblazer who opened doors and windows of opportunity for others to follow.

Long before there was a KAY BAILEY HUTCHISON, DIANNE FEINSTEIN, OLYMPIA SNOWE or MARIA CANTWELL in the U.S. Senate, there was Paula Hawkins. In 1980, she became the first woman elected to that august body for a full term without the benefit of family connections, and she was the first woman from Florida to serve as a Senator.

And to the surprise of no one who knew her, she was no shrinking violet in Washington once she arrived. The media may have dismissively billed her as that "housewife from Maitland," but she quickly showed everyone that this was one tough homemaker who was acclimated to the political kitchen and could weather the heat that goes with it. I mean to tell you she was tough.

Anyone who knows Paula also knows that she was always impeccably

dressed. Indeed, her appearance was so picture-perfect that she probably made many a Hollywood starlet feel shabby by comparison. To say she was dressed to the nines is like saying Jack Nicklaus was a fair golfer or that Shakespeare sort of had a way with words.

But Paula was more than a pretty face. Sure, she had perfectly coiffed hair and wore designer clothes and jewelry, but she had a razor-sharp mind to go with her smart appearance, and she quickly showed she was nobody's pushover. She could stand toe to toe and verbally slug it out with some of the most powerful and even most obnoxious Senators. In other words, she gave more than she got—and her opponents, more often than not, got more than they bargained for.

She was a great debater, a human dynamo who brought unrivaled energy and unbridled enthusiasm to the Senate. She was extremely intelligent and tremendously interested in politics—and she was very good at it. A quick look at her successful Senate campaign in 1980 attests to just how good she was.

By today's big-bucks standards, Paula's campaign was strictly bargain-basement. Fox News pundit Dick Morris, her pollster at the time, recalls the campaign being too cash-strapped to afford a teleprompter. Aides made do by writing scripts on paper towels and unrolling them as Paula spoke. In the end, her powers of persuasion and command of the facts carried the day with voters.

After stirring voters' hearts in Florida, Paula stirred things up in the Nation's Capital. Change was in the wind when she blew into wintry Washington in January 1981. For starters, she became the first Senator to bring her husband to Washington, which resulted in the Senate wives' club being renamed the Senate spouses' club. She helped spearhead legislation to help widows and women divorcees get back into the job market. She supported efforts to improve pensions for women and make them more equal to that of men. She further fought to get daycare for the children of Senate employees. Even the all-male Senate gym was no sweat for Paula, who forced her fellow Senators to wear swimming suits so that she could swim there as well.

To me, Paula was a ray of Florida sunshine that brightened my days during the years we served together in the Senate. She was a true blue conservative who was warm, witty and cracked wise. We shared many a joke and a laugh along with our commonly held moral, ethical and religious beliefs. And we became political allies and fast friends. In fact, Paula became and always remained one of my closest friends.

Both on and off Capitol Hill, she always could be counted on through good times and bad. I quickly learned that her word was her bond. Whenever I needed help, she was always there. And

I certainly hope the reverse was true—that I was there whenever she needed help.

Women, minorities, as well as the elderly with disabilities also learned they could count on Paula. She was a tireless advocate in their behalf—and they loved her for it. She also showed great political courage in 1984, when she disclosed during a hearing that she had been molested as a child. I am sure that horrific childhood experience, in part, informed her efforts to champion children's causes.

While her legislative accomplishments are too numerous to mention here, I would like to make mention of one in particular. Paula spearheaded the Missing Children's Act of 1982, the bill that instituted the National Center for Missing & Exploited Children. Thanks to that landmark legislation, the names of thousands of missing children are now part of the FBI's national crime database.

To secure the bill's passage, Paula personally lobbied President Reagan. As great a communicator as he was, the "Great Communicator" knew he had met his match in Paula and lent his support. Of course the President knew that Paula could always be relied on to help deliver a legislative win for "the Gipper" in the Senate—which she did many times.

As a staunch conservative, she found common cause with the President and other conservatives, including myself, on numerous issues. She was, for example, an ardent anti-communist who supported the President's hard line against Soviet expansionism. She also despised overly big government—and, there is certainly a lot to despise in Washington, especially these days.

Paula was an unwavering friend for those who shared her values and commitment, but she was an implacable foe of political corruption and to those who peddled illegal drugs on our streets and in our schools. She fought for legislation to cut foreign aid to nations that refused to reduce their export of harmful drugs. She further assisted in creating the Senate Caucus on International Narcotics Control and helped initiate the South Florida Drug Task Force.

I would be remiss if I didn't say something about Paula's stamina. She could endure as well as endear—often when she was in great pain. In 1982, she was knocked unconscious when a TV studio partition fell on her during an interview in Florida.

Those of us who worked closely with her know that the years that followed were often filled with crippling pain. Between votes on the Senate floor, she would often go to a room lent to her by Senator Strom Thurmond in the Capitol and lie in traction in a hospital bed.

Despite the immense pain stemming from her debilitating injury, Paula soldiered on during her 1986 bid for reelection. On campaign trips across Florida Paula would sometimes lay in

the back seat moaning between appearances, according to Congressman John Mica, her aide at the time. While she lost that race to Bob Graham, it is amazing that she did so well and a testament to her courage and determination.

Paula's service did not end with her Senate term. Her contributions to her State, community, family and church over the past 23 years have been truly significant. She also didn't lose her sense of humor. When a Florida State senator told Paula several years ago that she was trying to do a good job, Paula smiled, grasped her hand firmly and said simply: "Try harder, dear."

As great a public servant she was, Paula was just as remarkable in her private life—as a wife, mother, grandmother and great-grandmother. She had a fierce love for each member of her immediate and extended family. And her husband Gene is no less remarkable. He is one of the kindest, most friendly, decent and honorable men I have ever known—and his love for Paula has always been uplifting to behold.

In every aspect of their lives, they have been an exemplary couple. They have been just as exemplary as parents. As members of The Church of Jesus Christ of Latter-day Saints, Gene and Paula took to heart the Mormon teaching that families are forever. They were determined to ensure that every family member worked hard toward achieving the goal of being able to be together in the hereafter. They have a great family and are well on their way toward achieving that lofty goal.

In the Old Testament book of Proverbs, we read:

Who can find a virtuous woman, for her price is far above rubies. The heart of her husband doth safely trust in her, so that he shall have no need of spoil . . . She stretcheth out her hand to the poor; yea, she reacheth forth her hands to the needy . . . Strength and honor are her clothing; and she shall rejoice in the time to come . . . She looketh well to the ways of her household, and eateth not the bread of idleness. Her children arise up, and call her blessed; her husband also, and he praiseth her . . . Favour is deceitful and beauty is vain; but a woman that feareth the Lord, she shall be praised. Give her of the fruit of her hands; and let her own works praise her in the gates (Proverbs 31:10-31).

Today, I am honored to have the privilege of adding my voice to the chorus of praise for my dear friend, Paula Hawkins. I feel deeply that a loving Father in heaven and Jesus Christ have already embraced Paula and taken her into their care and treatment as one of truly great women who graced this Earth.

I truly loved Paula Hawkins. We were best friends. Like Gene and the Hawkins' three children—Genean, Kevin and Kelly—11 grandchildren and 10 great-grandchildren, my wife Elaine and I look forward to a joyous reunion one day with Paula on the other side of the veil.

In the meantime, it is my hope that all of us here in this chamber will re-

flect on her service and follow her advice to that State Senator: Try Harder!

#### ADDITIONAL STATEMENTS

##### TRIBUTE TO ROY OBREITER

• Mr. LEVIN. Mr. President, the Office of Rural Development within the United States Department of Agriculture will soon say goodbye to Roy Obreiter, a longtime trusted adviser, friend, and colleague to all who have worked with him. I am delighted to have this opportunity to pay tribute to Roy, a staff appraiser with the agency in Michigan, who will retire after 38 years of dedicated service. I join many within the USDA, as well as the many who have benefitted from his work over the years, in celebrating this impressive milestone.

Roy has an encyclopedic knowledge of agency programs and appraisal guidelines. Through his hard work, focus, and passion, Roy has endeared himself to those who have had the pleasure of working with him.

Roy has been a role model and mentor to his peers and coworkers. His kind and gentle demeanor, combined with his ability to connect on a personal level, have helped him earn the respect and admiration of his colleagues within the agency. Roy is an incredibly decent human being, devoted to family and work, and loyal to those around him.

Beyond his personal qualities, Roy has distinguished himself with a remarkable record of contributions to the agency. The assistance he has provided to Rural Development programs during his career has been invaluable. Roy can be proud of his contributions to Michigan and to rural America. He will be missed by his colleagues and by those throughout Michigan who have been touched by his work.

I congratulate Roy Obreiter on a job well done and wish him the best as he embarks on the next phase of his life.●

##### TRIBUTE TO TERRY SHERWOOD

• Mrs. LINCOLN. Mr. President, today I join many of my fellow Arkansans in recognizing and thanking Terry Sherwood with the Southwest Arkansas Planning and Development District for his 40 years of work with this agency and to wish him all the best in his retirement.

Since the Southwest Arkansas Planning and Development District was organized and began operation in 1967, it has served local governments by working as an indispensable partner to identify and implement State and Federal programs. Through Terry's hard work and leadership with the Southwest Arkansas Planning and Development District, communities throughout southwest Arkansas have been positively impacted and their lasting results are a testament to his dedication and vision and will be felt for decades to come.

Not only has Terry admirably served in his chosen career, but he has also offered his talents and expertise to a variety of local, state and national organizations. Terry has served as past President and board member of the National Association of Development Organizations, chairman of the Arkansas I-69 Association and vice-president of Arkansas Good Roads, board member of the Council of Peers and Southwest Regional Economic Development Association, chairman of the Association of Delta Development Districts, member of the Arkansas Highway and Transportation Public Participation's Committee, and a member of the Arkansas Association of Development Organizations. Terry's efforts have enhanced the lives of the citizens of our state. I am thankful for his work and his friendship and wish him a productive retirement.

I am proud to represent Terry in the U.S. Senate and pleased to have this opportunity today to publicly thank him for his contributions to the State of Arkansas and the people he touched.●

● Mr. PRYOR. Mr. President, today I pay tribute to the professional career and community achievements of Terry Sherwood of Magnolia, AR.

Terry Sherwood, a graduate of Michigan State University, began working as an employee of Southwest Arkansas Planning and Development District, Inc. in 1969. His hard work and dedication showed as he became the executive director in January 1992. He has provided the people of Arkansas with many accomplishments that are spread throughout the State.

He has served on several boards in several leadership roles such as past president and board member of the National Association of Development Organizations, NADO, vice president and member of the executive board of the I-69 Mid-Continent Highway Coalition, chairman of the Arkansas I-69 Association, vice-president of Arkansas Good Roads, board member of the Council of Peers Southeast Regional Executive Directors Institute, board member of the Southwest Regional Economic Development Association, chair of the Association of Delta Development Districts Delta Regional Authority, member of the Public Participation Committee Arkansas Highway and Transportation Department, and member of Arkansas Association of Development Organizations.

Terry has brought great leadership and outstanding integrity to the south Arkansas community. His leadership is unique and has inspired many other people in the area to get involved in their local neighborhoods and towns.

Mr. President, I ask that my colleagues join me in recognizing the great contributions Terry Sherwood has made to Arkansas and the United States of America.●

#### MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, one of his secretaries.

#### EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

#### MESSAGES FROM THE HOUSE

At 10:03 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 118. An act to authorize the addition of 100 acres to Morristown National Historical Park.

H.R. 1454. An act to provide for the issuance of a Multinational Species Conservation Funds Semipostal Stamp.

H.R. 1672. An act to reauthorize the Northwest Straits Marine Conservation Initiative Act to promote the protection of the resources of the Northwest Straits, and for other purposes.

H.R. 2062. An act to amend the Migratory Bird Treaty Act to provide for penalties and enforcement for intentionally taking protected avian species, and for other purposes.

H.R. 3388. An act to modify the boundary of Petersburg National Battlefield in the Commonwealth of Virginia, and for other purposes.

H.R. 3804. An act to make technical corrections to various Acts affecting the National Park Service, to extend, amend, or establish certain National Park Service authorities, and for other purposes.

H.R. 3940. An act to amend Public Law 96-597 to clarify the authority of the Secretary of the Interior to extend grants and other assistance to facilitate political status public education programs for the peoples of the non-self-governing territories of the United States.

#### ENROLLED BILL SIGNED

At 3:16 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled bill:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

At 4:27 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 4218. An act to amend titles II and XVI of the Social Security Act to prohibit retroactive payments to individuals during periods for which such individuals are prisoners, fugitive felons, or probation or parole violators.

The message also announced that the House disagrees to the amendment of

the Senate to the bill (H.R. 3288) "making appropriations for the Departments of Transportation, and Housing and Urban Development, and related agencies for the fiscal year ending September 30, 2010, and for other purposes"; it agrees to the conference asked by the Senate on the disagreeing votes of the two Houses thereon, and appoints Mr. OLVER, Mr. PASTOR, Ms. KAPTUR, Mr. PRICE of North Carolina, Ms. ROYBAL-ALLARD, Mr. BERRY, Ms. KILPATRICK of Michigan, Mrs. LOWEY, Mr. OBEY, Mr. LATHAM, Mr. WOLF, Mr. TIAHRT, Mr. WAMP, and Mr. LEWIS of California, as managers of the conference on the part of the House.

#### MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 118. An act to authorize the addition of 100 acres to Morristown National Historical Park; to the Committee on Energy and Natural Resources.

H.R. 1454. An act to provide for the issuance of a Multinational Species Conservation Funds Semipostal Stamp; to the Committee on Homeland Security and Governmental Affairs.

H.R. 2062. An act to amend the Migratory Bird Treaty Act to provide for penalties and enforcement for intentionally taking protected avian species, and for other purposes; to the Committee on Environment and Public Works.

H.R. 3388. An act to modify the boundary of Petersburg National Battlefield in the Commonwealth of Virginia, and for other purposes; to the Committee on Energy and Natural Resources.

H.R. 3804. An act to make technical corrections to various Acts affecting the National Park Service, to extend, amend, or establish certain National Park Service authorities, and for other purposes; to the Committee on Energy and Natural Resources.

H.R. 3940. An act to amend Public Law 96-597 to clarify the authority of the Secretary of the Interior to extend grants and other assistance to facilitate political status public education programs for the peoples of the non-self-governing territories of the United States; to the Committee on Energy and Natural Resources.

#### MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times by unanimous consent, and placed on the calendar:

H.R. 1672. An act to reauthorize the Northwest Straits Marine Conservation Initiative Act to promote the protection of the resources of the Northwest Straits, and for other purposes.

#### EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-3964. A communication from the Commissioner of the Social Security Administration, transmitting, the report of a proposed bill to amend titles II and XVI; to the Committee on Finance.

EC-3965. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Quarterly Listings; Safety Zones; Security Zones; Special Local Regulations; Regulated Navigation Areas; Drawbridge Operation Regulations" (Docket No. USG-2009-1039) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

### EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. KERRY for the Committee on Foreign Relations.

\*Rajiv J. Shah, of Washington, to be Administrator of the United States Agency for International Development.

\*Mary Burce Warlick, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Serbia.

Nominee: Mary Burce Warlick.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, amount, date, and donee:

1. Self: None.
2. Spouse: James B. Warlick, Jr., None.
3. Children and Spouses: James B. Warlick, III, None; Jason A. Warlick, None; Jordan V. C. Warlick, None.
4. Parents: Willard and Elinor Burce, \$35.00, 8/14/08, Republican National Committee; \$25.00, 10/3/08, Republican National Committee; \$35.00, 10/30/08, Republican National Committee.
5. Grandparents: Deceased.
6. Brothers and Spouses: Gregory C. Burce and Jan Rhodes: \$30.00, 2/20/08, Obama for America; \$30.00, 2/20/08, Al Franken for Senate; \$25.00, 8/21/08, Al Franken for Senate; \$25.00, 8/21/08, Obama for America; \$25.00, 9/21/08, Obama for America; \$25.00, 12/20/08, Al Franken for Senate; \$25.00, 4/16/08, Democratic Legislative Campaign Committee; Jerome E. and Nancy Burce: None; Charles A. Burce: None.
7. Sisters and Spouses: Amy E. Burce, \$25.00, 3/18/08, Obama for America; \$25.00, 5/31/08, Obama for America; \$25.00, 11/02/08, Obama for America; Juliana and Brian Tanning: None; Carrie and Myron Koehn: None.

\*James B. Warlick, Jr., of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Bulgaria.

Nominee: James B. Warlick, Jr.

Post: Sofia, Bulgaria.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions and amount:

1. Self: None.
2. Spouse: None.
3. Children and Spouses: None.
4. Parents: None.
5. Grandparents: None.

6. Brothers and Spouses: None.
7. Sisters and Spouses: None.

\*Eleni Tsakopoulos Kounalakis, of California, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Hungary.

Nominee: Eleni Tsakopoulos Kounalakis.

Post: Hungary.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, Amount, Date, and Donee:

1. Self: \$1,998.11, 2/7/2005, Doris Matsui for Congress; \$2,000, 3/21/2005, Olympia Snowe for Senate; \$26,700, 3/21/2005, DCCC; \$1,000, 3/21/2005, Arizona Democratic Party/Federal; \$4,000, 3/28/2005, Van Hollen for Congress; \$500, 3/24/2005, Friends of Dennis Cardoza; \$4,200, 4/4/2005, Mike Thompson for Congress; \$5,000, 4/19/2005, VINE PAC; \$1,000, 4/26/2005, Keeping America's Promise; \$4,200, 6/13/2005, Friends of Hillary Clinton; \$5,000, 8/25/2005, Searchlight Leadership Fund; \$4,200, 9/2/2005, Cantwell 2006; \$2,100, 11/14/2005, John Sarbanes for Congress; \$2,100, 11/4/2005, Bilirakis for Congress; \$2,100, 2/21/2006, Doris Matsui for Congress; \$3,246.44, 2/22/2006, Feinstein for Senate; \$4,200, 3/13/2006, Stabenow for US Senate; \$5,000, 3/17/2006, DSCC; \$2,100, 4/7/2006, Francine Busby for Congress; \$10,000, 6/30/2006, DSCC of CA; \$5,000, 9/5/2006, HILL PAC; \$500, 9/27/2006, John Sarbanes for Congress; \$2,100, 10/17/06, Amy Klobuchar (In preparing this report, we discovered that this contribution was reported by the Kolbucher for Minnesota committee as a contribution from Eleni Tsakopoulos and not from Alexandra Tsakopoulos. This appears to have been an inadvertent reporting error by the committee.); \$1,936.55 10/18/2006 DCCC; \$1,000, 2/8/2007, Emily's List; \$2,300, 2/21/2007, Hillary Clinton for President; \$320, 2/20/2007, Friends of Patrick Kennedy; \$1,000, 3/29/2007, The Reed Committee; \$28,500, 3/7/2007, DCCC; \$28,500, 3/29/2007, DSCC; \$1,000, 4/6/2007, Competitive Edge PAC; \$4,600, 5/7/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for President; \$4,600, 5/24/2007, Friends of Harry Reid; \$2,300, 5/21/2007, Zack Space for Congress; \$500, 5/23/2007, Al Franken for US Senate; \$500, 6/15/2007, Udall for Colorado; \$2,300, 9/21/2007, Niki Tsongas for Congress; \$2,300, 11/27/2007, Jeanne Shaheen for Senate; \$2,300, 11/27/2007, Honda for Congress; \$1,000, 2/21/2008, Kristen Gillibrand for Congress; \$2,300, 5/12/2008, Zack Space for Congress; \$2,300, 5/12/2008, Titus for Congress; \$4,600, 6/10/2008, Obama for America; \$2300 6/10/2008, Obama for America; \$(2300), 6/10/2008, Obama for America refund; \$6,500, 9/22/2008, DNC/Obama Victory Fund; \$2,300, 9/29/2008, Titus for Congress; \$2,300, 10/14/2008, Al Franken for US Senate; \$2,300, 10/14/2008, Jill Derby for Congress; \$215, 3/24/2009, DSCC of CA.

2. Spouse: Markos Kounalakis:

(My husband does not make contributions because he is a journalist. However, on occasion, when I have made a contribution with a check payable on a joint checking account, the contribution has been incorrectly attributed to him including the following during the relevant time period:)

\$2,300, 3/6/2007, Hillary Clinton for President (contribution refunded on 10/6/2008).

3. Children: Antoneo: None.

Evangelos: None.

Spouses: None.

4. Parents: Angelo Tsakopoulos: \$2,000, 1/21/2005, Doris Matsui for Congress; \$2,000, 3/18/2005, Olympia Snowe for Senate; \$26,700, 3/21/2005, DCCC; \$4,200, 4/5/2005, Mike Thompson for Congress; \$5,000, 4/20/2005, VINE PAC;

\$4,200, 6/6/2005, Friends of Hillary Clinton; \$5,000, 8/26/2005, Searchlight Leadership Fund; \$2,100, 11/11/2005, John Sarbanes for Congress; \$2,100, 11/16/2005, Bilirakis for Congress; \$4,200, 2/21/2006, Feinstein for Senate; \$4,200, 3/13/2006, Stabenow for US Senate; \$2,100, 4/4/2006, Francine Busby for Congress; \$4,200, 5/18/2006, John Doolittle for Congress; \$10,000, 6/30/2006, Democratic State Central Committee of CA-Levin Funds Account; \$5,000, 8/31/2006, HILL PAC; \$2,100, 9/7/2006, Madrid for Congress; \$2,100, 9/7/2006, Arcuri for Congress; \$2,100, 9/7/2006, Kilroy for Congress; \$500, 9/27/2006, John Sarbanes for Congress; \$1,900, 10/5/2006, Bilirakis for Congress; \$15,000, 11/1/2006, DCCC; \$4,600, 2/21/2007, Hillary Clinton for President (\$2,300 redesignated to Friends of Hillary Clinton on 7/21/2008); \$1,000, 2/16/2007, Friends of Patrick Kennedy; \$26,700, 2/21/2007, DCCC; \$500, 2/21/2007, Doris Matsui for Congress; \$28,500, 3/28/2007, DSCC; \$5,000, 4/10/2007, Calumet PAC; \$4,600, 5/7/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for President; \$4,600, 5/24/2007, Friends of Harry Reid; \$2,300, 5/16/2007, Zack Space for Congress; \$500, 6/17/2007, Udall for Colorado; \$2,300, 9/20/2007, Niki Tsongas for Congress; \$2,300, 10/31/2007, Bilirakis for Congress; \$2,300, 12/28/2007, Dean Scontras for Congress; \$2,300, 1/24/2008, Jared Polis for Congress; \$500, 2/29/2008, Wexler for Congress; \$200, 3/28/2008, Lungren for Congress; \$2,300, 4/4/2008, Solis for Congress; \$2,300, 5/8/2008, Zack Space for Congress; \$1,600, 5/12/2008, Titus for Congress; \$1,600, 5/13/2008, Bilirakis for Congress; \$1,000, 3/5/2009, Lungren for Congress.

Elaine Tsakopoulos: \$1,000, 6/3/2005, Friends of Hillary Clinton; \$1,000, 6/15/2007, Hillary Clinton for President; \$2,000, 12/10/2007, Hillary Clinton for President (\$700 refunded on 8/28/2008); \$2,300, 10/20/2008, Obama for America/Obama Victory Fund.

5. Grandparents: Deceased

6. Brothers: Kyriakos Tsakopoulos (no spouse): \$1,907, 6/28/2006, John Sarbanes for Congress; \$10,000, 10/10/2006, Democratic State Central Committee of CA—Levin Funds Account; \$26,700, 10/24/2006, DCCC; \$28,500, 3/7/2007, DCCC; \$500, 6/10/2007, Udall for Colorado; \$4,600, 12/28/2007, Hillary Clinton for President (\$2,300 refunded on 8/28/2008); \$2,300, 12/28/2007, Dean Scontras for Congress; \$2,300, 4/1/2008, Obama for America; \$500, 6/7/2008, Mitakides for Congress; \$28,500, 7/28/2008, DNC/Obama Victory Fund (\$2,300 refunded from Obama for America on 8/31/2008).

7. Sisters: Katina Tsakopoulos (no spouse): \$2,000, 1/20/2005, Doris Matsui for Congress; \$2,000, 3/18/2005, Olympia Snowe for Senate; \$26,700, 3/22/2005, DCCC; \$4,200, 5/4/2005, Mike Thompson for Congress; \$5,000, 5/4/2005, VINE PAC; \$2,100, 6/1/2005, Doris Matsui for Congress; \$4,200, 6/13/2005, Friends of Hillary Clinton; \$5,000, 8/25/2005, Searchlight Leadership Fund; \$2,100, 10/25/2005, Francine Busby for Congress; \$2,100, 11/11/2005, John Sarbanes for Congress; \$2,100, 11/18/2005, Bilirakis for Congress; \$4,200, 4/7/2006, Francine Busby for Congress; \$24,700, 5/23/2006, DCCC; \$2,100, 9/8/2006, Madrid for Congress; \$2,100, 9/8/2006, Arcuri for Congress; \$2,100, 9/8/2006, Kilroy for Congress; \$2,100, 9/27/2006, John Sarbanes for Congress; \$2,100, 10/5/2006, Bilirakis for Congress; \$2,100 10/19/2006, Francine Busby for Congress; \$2,100, 10/25/2006, Zach Space for Congress; \$4,600, 2/12/2007, Hillary Clinton for President (\$2,300 refund received on 8/28/2008); \$1,000 2/16/2007, Friends of Patrick Kennedy; \$28,500, 3/7/2007, DCCC; \$4,600, 5/4/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for Congress; \$2,300, 9/17/2007, Zach Space for Congress; \$2,300, 3/7/2008, Susan Davis for Congress; \$2,300, 5/12/008, Titus for Congress.

Athena Tsakopoulos (no spouse): \$2,000, 1/24/2005, Doris Matsui for Congress; \$2,000, 3/21/2005, Olympia Snowe for Senate; \$4,200, 4/13/2005, Mike Thompson for Congress; \$5,000, 4/29/2005, VINE PAC; \$4,200, 6/16/2005, Friends of

Hillary Clinton; \$2,100, 11/11/2005, John Sarbanes for Congress; \$2,100, 11/18/2005, Bilirakis for Congress; \$847.97, 2/28/2006, Feinstein for Senate; \$2,100, 4/4/2006, Francine Busby for Congress; \$4,200, 5/16/2006, Francine Busby for Congress; \$10,000 6/30/2006, Democratic State Central Committee of California Levin Funds Account; \$5,000, 8/31/2006, HILL PAC; \$25,000 9/8/2006, DSCC/Senate Victory Fund; \$2,100, 9/8/2006, Madrid for Congress; \$2,100, 9/8/2006, Arcuri for Congress; \$2,100, 9/8/2006, Kilroy for Congress; \$2,100, 9/27/2006, John Sarbanes for Congress; \$2,100, 10/25/2006, Zach Space for Congress; \$10,000, 11/1/2006, DCCC; \$4,600, 2/12/2007, redesignated to Friends of Hillary Clinton on 7/10/2008; \$1,000, 2/16/2007, Friends of Patrick Kennedy; \$4,600, 5/4/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for Congress; \$2,300, 9/11/2007, Zach Space for Congress; \$2,300, 5/12/2008, Zach Space for Congress; \$2,300, 5/12/2008, Titus for Congress; \$2,300, 10/23/2008, Obama for America; \$26,200, 10/31/2008, DNC/Obama Victory Fund.

Chrysanthy Tsakopoulos (no spouse); \$2,000, 1/21/2005, Doris Matsui for Congress; \$2,000, 3/18/2005, Olympia Snowe for Senate; \$26,700, 3/22/2005, DCCC; \$4,200, 4/6/2005, Mike Thompson for Congress; \$5,000, 4/19/2005, VINE PAC; \$4,200, 6/6/2005, Friends of Hillary Clinton; \$5,000, 8/26/2005, Searchlight Leadership Fund; \$2,100, 11/11/2005, John Sarbanes for Congress; \$2,100, 11/18/2005, Bilirakis for Congress; \$4,200, 2/21/2006, Feinstein for Senate; \$4,200, 3/12/2006, Stabenow for US Senate; \$2,100, 4/4/2006, Francine Busby for Congress for special election on 4/11/06; \$4,200, 5/16/2006, Francine Busby for Congress \$2100 for special runoff election held on 6/6/2006 and \$2100 for primary election held on 6/6/2006; \$10,000, 6/30/2006, Democratic State Central Committee of California Levin Funds Account; \$5,000, 8/31/2006, HILL PAC; \$2,100, 9/20/2006, Zach Space for Congress; \$2,100, 9/27/2006, John Sarbanes for Congress; \$2,100, 10/5/2006, Bilirakis for Congress; \$10,000, 10/18/2006, DCCC; \$1,000, 10/30/2006, Montana Democratic Party/Federal; \$4,600, 2/12/2007, Hillary Clinton for President (2,300 redesignated to Friends of Hillary on 8/28/2008; \$1,000, 2/16/2007, Friends of Patrick Kennedy; \$28,500, 3/7/2007, DCCC; \$4,600, 5/4/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for Congress; \$500, 6/14/2007, Udall for Colorado; \$2,300, 9/17/2007, Zach Space for Congress; \$2,300, 9/20/2007, Niki Tsongas for Congress; \$2,300, 11/28/2007, Jim Costa for Congress; \$2,300, 5/12/2008, Titus for Congress; \$2,300, 6/30/2008, Zach Space for Congress; \$2,300, 10/23/2008, Obama for America; \$26,200, 10/31/2008, DNC/Obama Victory Fund; \$2,300, 10/23/2008, Bilirakis for Congress; \$4,800, 3/24/2009, Alexi for Illinois Exploratory Committee.

Alexandra Tsakopoulos (no spouse); \$5,000, 8/26/2005, Searchlight Leadership Fund; \$2,100, 11/11/2005, John Sarbanes for Congress; \$2,100, 11/18/2005, Bilirakis for Congress; \$4,200, 2/21/2006, Feinstein for Senate; \$44,200, 3/12/2006, Stabenow for US Senate; \$2,100, 4/4/2006, Francine Busby for Congress for special election on 4/11/06; \$4,200, 5/16/2006, Francine Busby for Congress \$2100 for special runoff election held on 6/6/2006 and \$2100 for primary election held on 6/6/2006; \$10,000, 6/30/2006, Democratic State Central Committee of California Levin Funds Account; \$2,000, 8/29/2006, Honda for Congress; \$5,000, 8/31/2006, HILL PAC; \$25,000, 9/8/2006, DSCC/Senate Victory Fund; \$25,000, 9/8/2006, DCCC/House Victory Fund; \$2,100, 9/8/2006, Madrid for Congress; \$2,100, 9/8/2006, Arcuri for Congress; \$2,100, 9/8/2006, Kilroy for Congress; \$2,100, 9/20/2006, Zach Space for Congress; \$2,100, 9/27/2006, John Sarbanes for Congress; \$2,100, 10/5/2006, Bilirakis for Congress; \$10,000, 10/18/2006, DCCC; \$1,000, 10/30/2006, Montana Democratic Party/Federal; \$4,600, 2/12/2007, Hillary Clinton for President (2,300 redesignated to

Friends of Hillary on 8/28/2008); \$1,000, 2/16/2007, Friends of Patrick Kennedy; \$28,500, 3/7/2007, DCCC; \$4,600, 5/4/2007, Mike Thompson for Congress; \$2,300, 5/11/2007, Tom Vilsack for Congress; \$500, 6/14/2007, Udall for Colorado; \$2,300, 9/11/2007, Zach Space for Congress; \$2,300, 9/20/2007, Niki Tsongas for Congress; \$2,300, 11/28/2007, Jeanne Shaheen for Senate; \$2,300, 11/28/2007, Honda for Congress; \$2,300, 8/11/2008, Jeanne Shaheen for Senate; \$2,300, 9/19/2008, Obama for America; \$26,200, 9/19/2008, DNC/Obama Victory Fund.

\*Leslie V. Rowe, of Washington, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Mozambique.

Nominee: Leslie V. Rowe.

Post: Mozambique.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, amount, date, and donee:

1. Self: None.
2. Theodore Einar Dieffenbacher, Spouse: None.
3. Children: Paul Vicente Dieffenbacher, None; Daniele Dieffenbacher, None; Jacqueline Liisa Dieffenbacher, None.
4. Parents: Sara Ventura Rowe—deceased; John Leslie Rowe—deceased; Leon Ventura—deceased; Pauline Ventura—deceased; John E. Rowe—deceased; Mary E. Rowe—deceased.
5. Sister: Nancy Ventura Rowe; None.

\*Alberto M. Fernandez, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Equatorial Guinea.

Nominee: Alberto M. Fernandez.

Post: Ambassador to Equatorial Guinea.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, amount, date, and donee

1. Self: None.
2. Spouse: Katy Fernandez: None.
3. Children: Josrah P. Fernandez; None; Adam F. Fernandez; None.
4. Parents: Diana Rodriguez; \$25.00; 7-23-08; John McCain; Jorge L. Rodriguez; None.
5. Grandparents—deceased; None.
6. Brother and Spouses: None.
7. Sister and Spouse: Diana Valencia; None; Guillermo Valencia; None.

\*Mary Jo Wills, of the District of Columbia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Mauritius, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Seychelles.

Nominee: Mary Jo Wills.

Post:

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, amount, date, donee:

1. Self: None.

2. Spouse: Calvin D. Wills, Sr.: None.

3. Children and Spouses: Calvin D. Wills, Jr., None; Anthony R. Wills, None.

4. Parents: Edna D. Randall; \$50.00; Barack Obama; Joseph R. Randall, Sr.—deceased.

5. Grandparents: Lenear B. Randall—deceased; Jessie Randall—deceased; Marie Barnett—deceased; George Denny—deceased.

6. Brothers and Spouses: George E. Randall, None; Dawn Randall, None; Joseph R. Randall, Jr., None; Angelia Randall, None.

7. Sisters and Spouses: Deborah I. Randall, None; Gloria Jean Randall, None; Toni M. Randall, \$150.00, Barack Obama.

\*Anne Slaughter Andrew, of Indiana, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Costa Rica.

Nominee: Anne Slaughter Andrew.

Post: Ambassador.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, Amount, Date, and Donee:

1. Self: \$2,100, 9/30/2005, Evan Bayh Committee; \$1,000, 6/9/2006, Ellsworth for Congress; \$250, 7/26/06, Mahoney for Florida; \$2,300, 9/30/2007, Hillary Clinton for President; \$100, 5/29/08, Obama for America; \$500, 6/24/2008, Obama for America; \$2,300, 7/8/2008, Obama for America; \$28,500, 8/4/2008, Obama Victory Fund/DNC; \$4,000 designated by DNC to Obama for America; \$24,500 designated by DNC to DNC; (\$2,300), 11/12/09, Refund by Obama for America.

2. Spouse: Joseph J. Andrew: \$5,000, 2005, Sonnenschein PAC; \$2,100, 9/30/2005, Evan Bayh Committee; \$5,000, 2006, Sonnenschein PAC; \$500, 4/27/2006, Ben Cardin for Senate; \$1,000, 6/27/2006, Hoosiers for Hill; \$500, 1/08/07, IN Dem Cong. Victory Cmte.; \$5,000, 2007, Sonnenschein PAC; \$2,300, 6/30/2007; Hillary Clinton for President; \$5,000, 2008, Sonnenschein PAC; \$504, 9/1/2008, Obama Victory Fund; \$3,000, 9/30/2008, Obama Victory Fund; \$5,000, 2009, Sonnenschein PAC; \$1,000, 5/1/2009, Harry Reid for U.S. Senate.

3. Children and Spouses: Will Andrew—None; Meredith Andrew—None.

4. Parents: Marjorie Slaughter—Deceased; Owen L. Slaughter, M.D.—Deceased.

5. Grandparents: Jack Slaughter—Deceased; Margaret Sullivan Slaughter—Deceased; Mr. and Mrs. George Specht—Deceased.

6. Brothers and Spouses: Owen Slaughter—None; Julie Slaughter (spouse); \$100, 2006, Baron Hill for Congress; \$100, 2008, Baron Hill for Congress; \$50, 2008, Obama for America; Mark Slaughter; \$2,300, 8/24/2008, 2008, Yarmuth for Congress; Martha Slaughter (spouse); \$2,300, 11/14/2007, Hillary Clinton for President; \$300, 1/27/2008, Citizens for Rick Stock; \$500, 5/5/2008, Friends of Scott Harper; \$500, 6/30/2008, Friends of Scott Harper; \$250, 10/23/2008, Friends of Bruce Lunsford.

7. Sisters and Spouses: Sara Slaughter; \$500, 4/25/2007, Obama for America; \$50, 10/2008, Obama for America; Tom Smith (spouse)—None; Lynne Hodge—None; Christopher Hodge (spouse)—None.

\*David Daniel Nelson, of Minnesota, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Oriental Republic of Uruguay.

Nominee: David D. Nelson.

Post: Montevideo.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform

me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, amount, date, and donee:

1. Self: David Nelson: \$0, n/a, n/a.
2. Spouse: Gloria Nelson: \$0, n/a, n/a.
3. Children and Spouses: Alexander D. Nelson: \$0, n/a, n/a.
4. Parents: Edmund K. Nelson: No donations, but ran for State Legislature in South Dakota, 2004 (he lost). Marlys M. Nelson: \$50, 2008, Republican Senatorial Campaign Committee.
5. Grandparents: Joel Nelson—deceased; Estelle Nelson—deceased; Albert Billman—deceased; Edith Billman—deceased.
6. Brothers and Spouses: none.
7. Sisters and Spouses: Suzanne Babich: \$50, 2008, Minn. State Republican Party; \$50, 2007, Minn. State Republican Party; \$50, 2006, Minn. State Republican Party, \$50, 2005, Minn. State Republican Party; Elizabeth Thorson: \$0, n/a, n/a; David Thorson: \$50, 2004, Doug Meslow; \$50, 2004, Rebecca Otto; \$50, 2006, Hutchinson/Reed; \$50, 2006, Matt Dean; \$50, 2006, Scott Wright; \$50, 2006, Thomas Huntley; \$356, 2009, AAFP PAC; \$100, 2009, MMA MEDPAC; \$356, 2008, AAFP PAC; \$100, 2008, MMA MEDPAC; \$356, 2007, AAFP PAC; \$100, 2007, MMA MEDPAC; \$356, 2006, AAFP PAC; \$100, 2006, MMA MEDPAC; \$356, 2005, AAFP PAC; \$100, 2005, MMA MEDPAC.

\*Betty E. King, of New York, to be Representative of the United States of America to the Office of the United Nations and Other International Organizations in Geneva, with the rank of Ambassador.

Nominee: Betty King.

Post: USUN Geneva.

(The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.)

Contributions, date, donee, and amount:

1. Self: 2009, Democratic National Committee; \$200, 2008 Barack Obama Presidential Campaign; \$1,750, 2008 Hillary for President; \$1,250, 2008, Democratic National Committee; \$150, 2007, Democratic National Committee; \$100, 2006, Harold Ford Senate Campaign; \$250, 2005, Paul Aronshen for Congress; \$100.

\*Laura E. Kennedy, of New York, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, for the rank of Ambassador during her tenure of service as U.S. Representative to the Conference on Disarmament.

\*Eileen Chamberlain Donahoe, of California, for the rank of Ambassador during her tenure of service as the United States Representative to the UN Human Rights Council.

\*Jide J. Zeitlin, of New York, to be Representative of the United States of America to the United Nations for U.N. Management and Reform, with the rank of Ambassador.

\*Jide J. Zeitlin, of New York, to be Alternate Representative of the United States of America to the Sessions of the General Assembly of the United Nations during his tenure of service as Representative of the United States of America to the United Nations for U.N. Management and Reform.

Mr. KERRY. Mr. President, for the Committee on Foreign Relations I report favorably the following nomination lists which were printed in the RECORD on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at

the Secretary's desk for the information of Senators.

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

\*Foreign Service nominations beginning with Christopher William Dell and ending with Mark J. Steakley, which nominations were received by the Senate and appeared in the Congressional Record on September 24, 2009. (minus 1 nominee: Barbara J. Martin)

\*Foreign Service nominations beginning with Carleene H. Dei and ending with Robert E. Wuertz, which nominations were received by the Senate and appeared in the Congressional Record on September 25, 2009. (minus 2 nominees: Earl W. Gast; R. Douglass Arbuckle)

\*Foreign Service nominations beginning with Jeffrey D. Adler and ending with Conrad William Turner, which nominations were received by the Senate and appeared in the Congressional Record on November 9, 2009.

\*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

#### INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. NELSON of Nebraska:

S. 2846. A bill to authorize the issuance of United States War Bonds to aid in funding of the operations in Iraq and Afghanistan; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. WHITEHOUSE (for himself and Mr. SCHUMER):

S. 2847. A bill to regulate the volume of audio on commercials; to the Committee on Commerce, Science, and Transportation.

By Mr. LAUTENBERG:

S. 2848. A bill to amend the Federal Food, Drug, and Cosmetic Act to require manufacturers of bottled water to submit annual reports, and for other purposes; to the Committee on Environment and Public Works.

By Ms. MURKOWSKI:

S. 2849. A bill to require a study and report on the feasibility and potential of establishing a deep water sea port in the Arctic to protect and advance strategic United States interests within the evolving and ever more important region; to the Committee on Armed Services.

By Mr. VITTER:

S. 2850. A bill to permit the use of Federal funds from the Community Development Block Grant Program to be used to remediate damage from the installation of tainted drywall, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. GRASSLEY:

S. 2851. A bill to make permanent certain education tax incentives, to modify rules relating to college savings plans, and for other purposes; to the Committee on Finance.

#### SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEVIN:

S. Res. 372. A resolution designating March 2010 as "National Autoimmune Diseases

Awareness Month" and supporting efforts to increase awareness of autoimmune diseases and increase funding for autoimmune disease research; to the Committee on the Judiciary.

#### ADDITIONAL COSPONSORS

S. 428

At the request of Mr. DORGAN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 428, a bill to allow travel between the United States and Cuba.

S. 696

At the request of Mr. CARDIN, the names of the Senator from Minnesota (Ms. KLOBUCHAR) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 696, a bill to amend the Federal Water Pollution Control Act to include a definition of fill material.

S. 762

At the request of Mrs. FEINSTEIN, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of S. 762, a bill to promote fire safe communities and for other purposes.

S. 841

At the request of Mr. KERRY, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 841, a bill to direct the Secretary of Transportation to study and establish a motor vehicle safety standard that provides for a means of alerting blind and other pedestrians of motor vehicle operation.

S. 878

At the request of Mr. LAUTENBERG, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 878, a bill to amend the Federal Water Pollution Control Act to modify provisions relating to beach monitoring, and for other purposes.

S. 936

At the request of Mr. LAUTENBERG, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 936, a bill to amend the Federal Water Pollution Control Act to authorize appropriations for sewer overflow control grants.

S. 1066

At the request of Mr. SCHUMER, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1066, a bill to amend title XVIII of the Social Security Act to preserve access to ambulance services under the Medicare program.

S. 1304

At the request of Mr. GRASSLEY, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1313

At the request of Mr. LUGAR, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1313, a bill to amend the Internal Revenue Code of 1986 to permanently extend and expand the charitable deduction for contributions of food inventory.

S. 1421

At the request of Mr. LEVIN, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of S. 1421, a bill to amend section 42 of title 18, United States Code, to prohibit the importation and shipment of certain species of carp.

S. 1524

At the request of Mr. KERRY, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1547

At the request of Mr. REED, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1547, a bill to amend title 38, United States Code, and the United States Housing Act of 1937 to enhance and expand the assistance provided by the Department of Veterans Affairs and the Department of Housing and Urban Development to homeless veterans and veterans at risk of homelessness, and for other purposes.

S. 1578

At the request of Mr. LEAHY, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 1578, a bill to amend chapter 171 of title 28, United States Code, (commonly referred to as the Federal Torts Claim Act) to extend medical malpractice coverage to free clinics and the officers, governing board members, employees, and contractors of free clinics in the same manner and extend as certain Federal officers and employees.

S. 1589

At the request of Ms. CANTWELL, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of S. 1589, a bill to amend the Internal Revenue Code of 1986 to modify the incentives for the production of biodiesel.

S. 1660

At the request of Ms. KLOBUCHAR, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1660, a bill to amend the Toxic Substances Control Act to reduce the emissions of formaldehyde from composite wood products, and for other purposes.

S. 1666

At the request of Ms. COLLINS, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 1666, a bill to require the Administrator of the Environmental Protection Agency to satisfy certain conditions before issuing to producers of mid-level ethanol blends a waiver from certain requirements under the Clean Air Act, and for other purposes.

S. 1822

At the request of Mr. MERKLEY, the name of the Senator from North Carolina (Mrs. HAGAN) was added as a cosponsor of S. 1822, a bill to amend the

Emergency Economic Stabilization Act of 2008, with respect to considerations of the Secretary of the Treasury in providing assistance under that Act, and for other purposes.

S. 1938

At the request of Mr. ROCKEFELLER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1938, a bill to establish a program to reduce injuries and deaths caused by cellphone use and texting while driving.

S. 2128

At the request of Mr. LEMIEUX, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2810

At the request of Mr. COCHRAN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 2810, a bill to require the Secretary of Agriculture to provide emergency disaster assistance to certain agricultural producers that suffered losses during the 2009 calendar year.

S. 2831

At the request of Mr. REED, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 2831, a bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes.

S. RES. 320

At the request of Mr. BOND, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. Res. 320, a resolution designating May 1 each year as "Silver Star Banner Day".

AMENDMENT NO. 2790

At the request of Mr. CASEY, the names of the Senator from New York (Mrs. GILLIBRAND) and the Senator from Rhode Island (Mr. REED) were added as cosponsors of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2807

At the request of Mr. CORNYN, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of amendment No. 2807 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2878

At the request of Mr. CARDIN, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Illinois (Mr. BURRIS), the Senator from New Jersey (Mr. MENENDEZ) and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of amend-

ment No. 2878 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2898

At the request of Mr. LIEBERMAN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of amendment No. 2898 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2909

At the request of Mr. NELSON of Florida, the names of the Senator from New York (Mrs. GILLIBRAND), the Senator from Pennsylvania (Mr. CASEY) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of amendment No. 2909 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2912

At the request of Mr. WHITEHOUSE, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of amendment No. 2912 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2913

At the request of Mr. WHITEHOUSE, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of amendment No. 2913 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2923

At the request of Mr. DORGAN, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of amendment No. 2923 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2930

At the request of Ms. STABENOW, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of amendment No. 2930 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of

the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2943

At the request of Mr. CARPER, the name of the Senator from New Hampshire (Mrs. SHAHEEN) was added as a cosponsor of amendment No. 2943 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2944

At the request of Mrs. BOXER, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of amendment No. 2944 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2957

At the request of Mr. BENNET, the names of the Senator from Illinois (Mr. DURBIN), the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of amendment No. 2957 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2961

At the request of Mrs. SHAHEEN, the names of the Senator from Alaska (Mr. BEGICH) and the Senator from Louisiana (Mr. VITTER) were added as cosponsors of amendment No. 2961 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2962

At the request of Mr. HATCH, the name of the Senator from Texas (Mr. CORNYN) was added as a cosponsor of amendment No. 2962 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

At the request of Mr. ISAKSON, his name was added as a cosponsor of amendment No. 2962 proposed to H.R. 3590, *supra*.

At the request of Mr. NELSON of Nebraska, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of amendment No. 2962 proposed to H.R. 3590, *supra*.

## AMENDMENT NO. 2969

At the request of Mr. COBURN, the name of the Senator from Nebraska (Mr. JOHANN) was added as a cospon-

sor of amendment No. 2969 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2991

At the request of Mr. MENENDEZ, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of amendment No. 2991 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2993

At the request of Mr. SCHUMER, the names of the Senator from Connecticut (Mr. DODD), the Senator from Massachusetts (Mr. KERRY) and the Senator from North Dakota (Mr. CONRAD) were added as cosponsors of amendment No. 2993 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## AMENDMENT NO. 2995

At the request of Mr. SCHUMER, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of amendment No. 2995 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. NELSON, of Nebraska:

S. 2846. A bill to authorize the issuance of United States War Bonds to aid in funding of the operations in Iraq and Afghanistan; to the Committee on Banking, Housing, and Urban Affairs.

Mr. NELSON of Nebraska. Mr. President, I rise today to introduce legislation to help finance the war effort without sharp tax increases or increased foreign borrowing. The United States War Bonds Act of 2009 will authorize the Treasury to issue and market War Bonds to the American people to help finance the wars in Afghanistan and Iraq.

I believe that we need shared sacrifice and fiscal discipline in financing the war effort. I don't believe our first instinct should always be a rush to tax. The government has gone to great lengths to address the economic downturn and adding new taxes right now could undermine those efforts. We need to work to reduce Federal spending wherever possible and reduce the growth in spending to finance the war.

War bonds are a cost-effective way to reduce our dependence on foreign creditors and create an outlet for Americans to express their patriotism and support for our servicemembers and America's mission. War bonds allow us to borrow from ourselves, rather than other countries.

This legislation finds a precedent in World War II savings bonds. From May 1, 1941 through December 1945, the War Finance Division and its predecessors were responsible for the sale of nearly \$186 billion worth of government securities. Of this, more than \$54 billion was in the form of War Savings bonds.

Although the times and economic circumstances are different than the 1940s, America's commitment to protecting freedom and our way of life has not waned. My hope is that we can tap into the same spirit of patriotism and create a sense of participation in the war effort akin to that shown by the greatest generation.

The new military strategy increasing troops by 30,000 for Afghanistan announced last week by President Obama is estimated to cost \$30 billion beyond the baseline for Iraq and Afghanistan funding, which stands around \$130 billion for 2010. The United States public debt is currently more than \$7.6 trillion and nearly \$3.5 trillion—46 percent—of the debt is held by foreign investors. While there are no simple solutions to our fiscal woes, while we endeavor to get our fiscal house in order, we must also be responsible borrowers and reduce our dependence on foreign creditors; this is a step in that direction.

By Mr. WHITEHOUSE (for himself and Mr. SCHUMER):

S. 2847. A bill to regulate the volume of audio on commercials; to the Committee on Commerce, Science, and Transportation.

Mr. WHITEHOUSE. Mr. President, I rise today to introduce the Commercial Advertisement Loudness Mitigation Act of 2009—the CALM Act. I want to thank my original cosponsor Senator SCHUMER for his support of this straightforward and commonsense legislation, which would require the Federal Communications Commission, FCC, to limit the volume of television advertisements to a level no louder than the average volume level of the programs during which the advertisements appear. This time for this Act is overdue. All too often over the years, Americans, sitting down after a long workday or workweek to enjoy their favorite television shows, have been assaulted by commercials at volumes that are degrees of magnitude louder than the shows themselves. The FCC first received enough complaints from viewers to look into the problem in the 1960s—when television was in its earliest stages—but technology did not exist to fix the problem. Each decade, as consumer complaints piled up, the FCC had to reexamine the loudness issue. Unfortunately, it took no action

even with the technology improved. The complaints continue to this day; in the 25 quarterly reports on consumer complaints released by the FCC since 2002, 21 have listed as a top complaint the loudness of television commercials.

But now, with the digital transition complete and new broadcast technology available, we can finally take this long-overdue action. We now have a common digital platform used by all broadcasters, which presents a terrific opportunity to standardize the loudness of the ads broadcast into our living rooms. As Consumers Union, the nonprofit organization that publishes Consumers Report has stated, in testimony before the House of Representatives, "the CALM Act provides an elegant and commonsense solution to finally ending a forty-five year consumer complaint in the United States."

The House has already begun its consideration of companion legislation, and I applaud the leadership of Representative ESHOO on this issue. The television industry has been deeply involved in the drafting of this legislation, and the standards it adopts are practicable, affordable, and effective. I hope my Senate colleagues will act quickly to pass the CALM Act and finally put an end to this longstanding irritation.

By Ms. MURKOWSKI:

S. 2849. A bill to require a study and report on the feasibility and potential of establishing a deep water sea port in the Arctic to protect and advance strategic United States interests within the evolving and ever more important region; to the Committee on Armed Services.

Ms. MURKOWSKI. Mr. President, as you are undoubtedly aware, the U.S. is an arctic Nation. As such, the U.S. must ensure that not only its economic and environmental interests in the region are protected, but also its national defense and homeland security interests. While the U.S. maintains a strong working relationship with the 7 other arctic nations—Canada, Denmark, Finland, Iceland, Norway, the Russian Federation and Sweden—these nations also have their own interests to protect in the arctic region. Despite those relationships, the U.S. cannot assume that these nations will protect our interests in the region. The ability for the U.S. to project its territorial claims and protect its economic interests in the arctic will become increasingly important as the arctic shipping lanes become more accessible as the seasonal arctic ice decreases. With the high potential for increased and industrial and commercial activity in the arctic region, the U.S. must ensure that it is prepared to protect human life as well as the vulnerable arctic environment.

With an expected increase in arctic activity on the horizon, the U.S. cannot wait until our interests in the region are threatened before we act. In that light, the Arctic Deep Water Sea

Port Act of 2009 is a major step towards protecting vital U.S. interests in the region. The Arctic Deep Water Sea Port Act of 2009 directs the Secretary of Defense, in consultation with the Secretary of Homeland Security, to conduct a study to determine the feasibility of establishing a deep water port in the arctic to protect U.S. strategic interests in the region. As the lead Departments for National Defense and Homeland Security initiatives for the U.S., the Department of Defense and the Department of Homeland Security, while working alongside their subordinate agencies, are best suited for determining and implementing policy decisions that protect U.S. sovereignty and national security.

This two-year study is designed to determine what strategic capabilities a deep water port could provide as well as an optimal location that would provide protection for a wide spectrum of U.S. initiatives. While studying the infrastructure needs for such a port, this study will also endeavor to determine the resource and timeframe needs to establish such a port, given the complex environmental constraints that the arctic marine environment provides. Upon completion of this study, the U.S. will be better positioned to understand the resource and development needs for the arctic region that are required to protect our interests in the region.

Mr. GRASSLEY:

S. 2851. A bill to make permanent certain education tax incentives, to modify rules relating to college savings plans, and for other purposes; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today I am offering legislation to make permanent a number of education-related tax relief measures. My legislation also improves and makes permanent helpful provisions for 529 plans and the American Opportunity tax credit for education.

At the first hearing I held when I became Chairman of the Finance Committee in 2001, I made clear that education tax policy was a priority of mine. As Chairman, I was able to remove the 60-payment limit for deducting student loan interest and I was able to increase the income limits for that deduction. This was not the only time I fought hard to allow students to deduct their student loan interest. In 1997, I was able to re-instate the student loan interest deduction that Congress had eliminated from our tax laws. However, the 60-payment limit on the deductibility of student loan interest remained. I ensured that the 2001 tax relief bill took care of that problem. Other incentives for education that I was able to enact into law in 2001 included raising the amount that can be contributed to an education saving account from \$500 to \$2,000; making distributions from pre-paid college savings plans and tuition plans tax-free; and making permanent the tax-free

treatment of employer-provided educational assistance. These tax policies and many others, including those for school renovations, repairs and construction, have proven their value to Iowa students in dollars and cents, year after year. The tax relief has delivered measureable educational assistance to Iowans and students and families nationwide, making education more affordable and accessible.

One draw-back of enacting these provisions in the 2001 tax relief bill, however, is that there was a sunset provision attached to that entire piece of legislation. All of the tax relief needs to be made permanent. Especially the education-related tax provisions. That is what my bill today does. My bill makes these provisions permanent.

It is no coincidence that I am introducing my education tax bill on the day the President of the United States talked about jobs. Our economy demands well-educated workers. The popularity of education tax incentives is good news for workers who find themselves unemployed or who want to go back to school to advance, or even change, their careers. Congress is willing to consider permanent tax relief for companies to buy machinery. Why isn't Congress willing to make an investment in people? That is what tax relief for education is. An investment in our future. It is just as important as job-creating tax incentives for businesses. Some will say we can't afford this, but we really can't afford to lose billions of dollars of help for Americans working hard to educate their kids.

Education has made this country great. We should not let this opportunity pass us by. We should not let these education-related tax provisions expire. We should also continue to help make education affordable for families and students. This makes education accessible for all. I look forward to working with my colleagues on passing this bill.

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

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

S. 2851

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

**SECTION 1. AMENDMENT OF 1986 CODE.**

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

**SEC. 2. PERMANENT EXTENSION AND INCREASE OF AMERICAN OPPORTUNITY TAX CREDIT.**

(a) PERMANENT EXTENSION OF CREDIT; INCREASE OF CREDIT AMOUNT.—Section 25A is amended—

(1) by striking "\$1,000" each place it appears in subsection (b)(1) and inserting "\$2,000";

(2) by striking "the applicable limit" in subsection (b)(1)(B) and inserting "\$4,000";

(3) by striking paragraph (4) of subsection (b),

(4) by striking “2 TAXABLE YEARS” in the heading of subparagraph (A) of subsection (b)(2) and inserting “4 TAXABLE YEARS”,

(5) by striking “2 prior taxable years” in subsection (b)(2)(A) and inserting “4 prior taxable years”,

(6) by striking “2 YEARS” in the heading of subparagraph (C) of subsection (b)(2) and inserting “4 YEARS”,

(7) by striking “first 2 years” in subsection (b)(2)(C) and inserting “first 4 years”,

(8) by striking “tuition and fees” in subparagraph (A) of subsection (f)(1) and inserting “tuition, fees, and course materials”,

(9) by striking paragraphs (1) and (2) of subsection (d) and inserting the following new paragraphs:

“(1) HOPE SCHOLARSHIP CREDIT.—The amount which would (but for this paragraph) be taken into account under paragraph (1) of subsection (a) for the taxable year shall be reduced (but not below zero) by the amount which bears the same ratio to the amount which would be so taken into account as—

“(A) the excess of—

“(i) the taxpayer’s modified adjusted gross income for such taxable year, over

“(ii) \$80,000 (\$160,000 in the case of a joint return), bears to

“(B) \$10,000 (\$20,000 in the case of a joint return).”

“(2) LIFETIME LEARNING CREDIT.—The amount which would (but for this paragraph) be taken into account under paragraph (2) of subsection (a) for the taxable year shall be reduced (but not below zero) by the amount which bears the same ratio to the amount which would be so taken into account as—

“(A) the excess of—

“(i) the taxpayer’s modified adjusted gross income for such taxable year, over

“(ii) \$40,000 (\$80,000 in the case of a joint return), bears to

“(B) \$10,000 (\$20,000 in the case of a joint return).”

(10) by striking “DOLLAR LIMITATION ON AMOUNT OF CREDIT” in the heading of paragraph (1) of subsection (h) and inserting “HOPE SCHOLARSHIP CREDIT”,

(11) by striking “2001” in subsection (h)(1)(A) and inserting “2011”,

(12) by striking “the \$1,000 amounts under subsection (b)(1)” in subsection (h)(1)(A) and inserting “the dollar amounts under subsections (b)(1) and (d)(1)”,

(13) by striking “calendar year 2000” in subsection (h)(1)(A)(ii) and inserting “calendar year 2010”,

(14) by striking “If any amount” and all that follows in subparagraph (B) of subsection (h)(1) and inserting “If any amount under subsection (b)(1) as adjusted under subparagraph (A) is not a multiple of \$100, such amount shall be rounded to the next lowest multiple of \$100. If any amount under subsection (d)(1) as adjusted under subparagraph (A) is not a multiple of \$1,000, such amount shall be rounded to the next lowest multiple of \$1,000.”,

(15) by inserting “OF LIFETIME LEARNING CREDIT” after “INCOME LIMITS” in the heading of paragraph (2) of subsection (h),

(16) by adding at the end of subsection (b) the following new paragraphs:

“(4) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—In the case of a taxable year to which section 26(a)(2) does not apply, so much of the credit allowed under subsection (a) as is attributable to the Hope Scholarship Credit shall not exceed the excess of—

“(A) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

“(B) the sum of the credits allowable under this subpart (other than this subsection and

sections 23, 25D, and 30D) and section 27 for the taxable year.

Any reference in this section or section 24, 25, 25B, 26, 904, or 1400C to a credit allowable under this subsection shall be treated as a reference to so much of the credit allowable under subsection (a) as is attributable to the Hope Scholarship Credit.

“(5) PORTION OF CREDIT MADE REFUNDABLE.—40 percent of so much of the credit allowed under subsection (a) as is attributable to the Hope Scholarship Credit (determined after the application of subsection (d)(1) and without regard to this paragraph and section 26(a)(2) or paragraph (4), as the case may be) shall be treated as a credit allowable under subpart C and not allowed under subsection (a). The preceding sentence shall not apply to any taxpayer for any taxable year if such taxpayer is a child to whom subsection (g) of section 1 applies for such taxable year.”, and

(17) by striking subsection (i).

(b) CONFORMING AMENDMENTS.—

(1) Section 24(b)(3)(B) is amended by striking “25A(i)” and inserting “25A(b)”.

(2) Section 25(e)(1)(C)(ii) is amended by striking “25A(i)” and inserting “25A(b)”.

(3) Section 26(a)(1) is amended by striking “25A(i)” and inserting “25A(b)”.

(4) Section 25B(g)(2) is amended by striking “25A(i)” and inserting “25A(b)”.

(5) Section 904(i) is amended by striking “25A(i)” and inserting “25A(b)”.

(6) Section 1400C(d)(2) is amended by striking “25A(i)” and inserting “25A(b)”.

(7) Section 6211(b)(4)(A) is amended by striking “25A by reason of subsection (i)(6) thereof” and inserting “25A by reason of subsection (b)(5) thereof”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(d) APPLICATION OF EGTRRA SUNSET.—The amendment made by subsection (b)(1) shall be subject to title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 in the same manner as the provision of such Act to which such amendment relates.

### SEC. 3. PERMANENT EXTENSION OF CERTAIN EGTRRA PROVISIONS RELATING TO EDUCATION.

(a) IN GENERAL.—Title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to the amendments made by sections 401, 402, 411, 412, 413, and 431 of such Act.

(b) CONFORMING AMENDMENT.—Section 222 is amended by striking subsection (e).

(c) EFFECTIVE DATE.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 2009.

### SEC. 4. PERMANENT EXTENSION OF DEDUCTION FOR CERTAIN EXPENSES OF ELEMENTARY AND SECONDARY SCHOOL TEACHERS.

(a) IN GENERAL.—Subparagraph (D) of section 62(a)(2) is amended by striking “during 2002, 2003, 2004, 2005, 2006, 2007, 2008, or 2009” and inserting “after 2001”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

### SEC. 5. PERMANENT EXTENSION OF QUALIFIED ZONE ACADEMY BONDS.

(a) IN GENERAL.—Paragraph (1) of section 54E(c) is amended by striking “and, except as provided in paragraph (4), zero thereafter” and inserting “and, except as provided in paragraph (5), \$700,000,000 for each calendar year thereafter”.

(b) INFLATION ADJUSTMENT.—Subsection (c) of section 54E is amended by adding at the end the following new paragraph:

“(5) INFLATION ADJUSTMENT.—In the case of any calendar year after 2011, the \$700,000,000 amount in paragraph (1) shall be increased by an amount equal to—

“(A) such amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of \$1,000,000, such increase shall be rounded to the next lowest multiple of \$1,000,000.”

(c) CREDITS NOT TO BE STRIPPED.—Section 54E is amended by adding at the end the following new subsection:

“(e) CREDITS NOT TO BE STRIPPED.—Subsection (i) of section 54A shall not apply with respect to any qualified zone academy bond.”

(d) DAVIS-BACON RULES NOT TO APPLY TO QZABS OR SCHOOL CONSTRUCTION BONDS.—Section 1601 of the American Recovery and Reinvestment Act of 2009 is amended by striking paragraphs (3) and (4), by inserting “and” at the end of paragraph (2), and by redesignating paragraph (5) as paragraph (3).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to obligations issued after December 31, 2010.

(2) DAVIS-BACON RULES.—The amendments made by subsection (d) shall apply to obligations issued after the date of the enactment of this Act.

### SEC. 6. PERMANENT EXTENSION OF SCHOOL CONSTRUCTION BONDS.

(a) IN GENERAL.—Subsection (c) of section 54F is amended—

(1) by striking paragraph (3),

(2) by inserting “and” at the end of paragraph (1), and

(3) by striking “for 2010, and” in paragraph (2) and inserting “thereafter”.

(b) ALLOCATIONS FOR INDIAN SCHOOLS.—Paragraph (4) of section 54F(d) is amended by striking “for calendar year 2010” and inserting “for each calendar year after 2009”.

(c) EXTENSION OF SMALL ISSUER EXCEPTION.—

(1) IN GENERAL.—Clause (vii) of section 148(f)(4)(D) is amended by striking “\$10,000,000” and inserting “\$15,000,000”.

(2) ELIMINATION OF EGTRRA SUNSET.—Title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to the amendments made by section 421 of such Act.

(d) CREDITS NOT TO BE STRIPPED.—Section 54F is amended by adding at the end the following new subsection:

“(f) CREDITS NOT TO BE STRIPPED.—Subsection (i) of section 54A shall not apply with respect to any qualified school construction bond.”

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to obligations issued after December 31, 2010.

### SEC. 7. PERMANENT EXTENSION AND MODIFICATION OF SECTION 529 RULES.

(a) IN GENERAL.—Clause (iii) of section 529(e)(3)(A) is amended by striking “in 2009 or 2010”.

(b) ABILITY TO CHANGE INVESTMENT OPTIONS.—Subsection (e) of section 529 is amended by adding at the end the following new paragraph:

“(6) ALLOWABLE CHANGE OF INVESTMENT OPTIONS.—A program shall not fail to be treated as meeting the requirements of subsection (b)(4) merely because such program allows a designated beneficiary to change investment options under the plan not more than 4 times per year.”

(c) EFFECTIVE DATES.—

(1) EXTENSION.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2010.

(2) INVESTMENT OPTIONS.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 2009.

## SUBMITTED RESOLUTIONS

## SENATE RESOLUTION 372—DESIGNATING MARCH 2010 AS “NATIONAL AUTOIMMUNE DISEASES AWARENESS MONTH” AND SUPPORTING EFFORTS TO INCREASE AWARENESS OF AUTOIMMUNE DISEASES AND INCREASE FUNDING FOR AUTOIMMUNE DISEASE RESEARCH

Mr. LEVIN submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 372

Whereas autoimmune diseases are chronic, disabling diseases in which underlying defects in the immune system lead the body to attack its own organs and tissues;

Whereas autoimmune diseases can affect any part of the body, including the blood, blood vessels, muscles, nervous system, gastrointestinal tract, endocrine glands, and multiple-organ systems, and can be life-threatening;

Whereas researchers have identified over 80 different autoimmune diseases, and suspect at least 40 additional diseases of qualifying as autoimmune diseases;

Whereas researchers have identified a close genetic relationship and a common pathway of disease that exists among autoimmune diseases, explaining the clustering of autoimmune diseases in individuals and families;

Whereas the family of autoimmune diseases is under-recognized, and poses a major health care challenge to the United States;

Whereas the National Institutes of Health (NIH) estimates that autoimmune diseases afflict up to 23,500,000 people in the United States, 75 percent of whom are women, and that the prevalence of autoimmune diseases is rising;

Whereas NIH estimates the annual direct health care costs associated with autoimmune diseases at more than \$100,000,000,000, with over 250,000 new diagnoses each year;

Whereas autoimmune diseases are among the top 10 leading causes of death in female children and adult women;

Whereas autoimmune diseases most often affect children and young adults, leading to a lifetime of disability;

Whereas diagnostic tests for most autoimmune diseases are not standardized, making autoimmune diseases very difficult to diagnose;

Whereas because autoimmune diseases are difficult to diagnose, treatment is often delayed, resulting in irreparable organ damage and unnecessary suffering;

Whereas the Institute of Medicine of the National Academies reported that the United States is behind other countries in research into immune system self-recognition, the cause of autoimmune diseases;

Whereas a study by the American Autoimmune Related Diseases Association revealed that it takes the average patient with an autoimmune disease more than 4 years, and costs more than \$50,000, to get a correct diagnosis;

Whereas there is a significant need for more collaboration and cross-fertilization of basic autoimmune research;

Whereas there is a significant need for research focusing on the etiology of all autoimmune-related diseases, in order to increase understanding of the root causes of these diseases rather than treating the symptoms after the disease has already had its destructive effect;

Whereas the National Coalition of Autoimmune Patient Groups is a coalition of na-

tional organizations focused on autoimmune diseases, working to consolidate the voices of patients with autoimmune diseases and to promote increased education, awareness, and research into all aspects of autoimmune diseases through a collaborative approach; and

Whereas designating March 2010 as “National Autoimmune Diseases Awareness Month” would help educate the public about autoimmune diseases and the need for research funding, accurate diagnosis, and effective treatments: Now, therefore, be it Resolved, That the Senate—

(1) designates March 2010 as “National Autoimmune Diseases Awareness Month”;

(2) supports the efforts of health care providers and autoimmune patient advocacy and education organizations to increase awareness of the causes of, and treatments for, autoimmune diseases; and

(3) supports the goal of increasing Federal funding for aggressive research to learn the root causes of autoimmune diseases, as well as the best diagnostic methods and treatments for people with autoimmune diseases.

Mr. LEVIN. Mr. President, this resolution designates March 2010 as National Autoimmune Diseases Awareness Month. The purpose of the resolution is to raise awareness of autoimmune diseases and the need for aggressive research to learn the root causes of autoimmune diseases, as well as the best diagnostic methods and treatments for people with autoimmune diseases.

Autoimmune diseases are chronic, disabling diseases in which underlying defects in the immune system lead the body to attack its own organs and tissues. They can affect any part of the body—blood, blood vessels, muscles, nervous system, gastrointestinal tract, endocrine glands, and multiple-organ systems—and can be life-threatening.

Researchers have identified over 80 different autoimmune diseases, including multiple sclerosis, rheumatoid arthritis, juvenile diabetes, Crohn’s disease, scleroderma, polymyositis, lupus, Sjogren’s disease and Graves’ disease, and suspect at least 40 additional diseases of having an autoimmune basis. The National Institutes of Health estimates that autoimmune diseases afflict more than 23 million people in the U.S. Seventy-five percent of the people affected with autoimmune diseases are women, and the prevalence of autoimmune diseases is rising. However, the family of autoimmune diseases is underrecognized, and this poses a major health care challenge to the U.S.

Diagnostic tests for autoimmune diseases are not standardized, which makes autoimmune diseases very difficult to diagnose. Because autoimmune diseases are difficult to diagnose, treatment is often delayed, resulting in irreparable organ damage and unnecessary suffering.

There is a significant need for more collaboration and cross-fertilization of basic autoimmune research, with a particular focus on the etiology of all autoimmune-related diseases in order to increase understanding of the root causes of these diseases rather than treating the symptoms after the disease has had its destructive effect.

It is my hope that this resolution will help educate the public about

autoimmune diseases and the continued need for research towards accurate diagnosis, and effective treatments.

## AMENDMENTS SUBMITTED AND PROPOSED

SA 3001. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3002. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3003. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3004. Mrs. HAGAN (for herself and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3005. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Ms. SNOWE, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3006. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Ms. SNOWE, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3007. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Ms. SNOWE, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3008. Ms. LANDRIEU (for herself, Ms. SNOWE, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3009. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Ms. SNOWE, and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3010. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Ms. SNOWE, Mr. DURBIN, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3011. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, Mrs. LINCOLN, Ms. SNOWE, Mr. WARNER, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.



Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3055. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3056. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3057. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3058. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3059. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3060. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3061. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3062. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3063. Mr. AKAKA (for himself and Mr. INOUE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3064. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3065. Mr. CARDIN (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3066. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3067. Mr. PRYOR (for himself, Mrs. BOXER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3068. Mr. KYL (for himself, Mr. ROBERTS, Mr. VITTER, Mr. GRASSLEY, Mr. CRAPO, Mr. COBURN, Mr. BARRASSO, and Mr. JOHANNES) submitted an amendment intended

to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3069. Mr. KOHL submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3070. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3071. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3072. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3073. Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3074. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3075. Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3076. Mr. DURBIN (for himself and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3077. Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3078. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

#### TEXT OF AMENDMENTS

**SA 3001.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

**SEC. 3316. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.**

(a) IN GENERAL.—Section 1860D-4(c)(2) of the Social Security Act (42 U.S.C. 1395w-104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs:

“(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

“(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

“(I) shall include a review of the individual’s medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

“(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

“(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

“(D) ASSESSMENT.—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

“(E) AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.—The prescription drug plan sponsor shall have in place a process to—

“(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

“(ii) permit such beneficiaries to opt-out of enrollment in such program.”

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

**SA 3002.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1722, after line 24, insert the following:

“(C) USE OF TECHNOLOGY.—The Secretary shall incorporate the use of technologies, including analytics and predictive modeling, as part of the analysis process for the purpose of identifying fraud, abuse, or improper payments prior to the payment of claims. Such analysis technologies shall at a minimum—

“(i) have the capability to detect emerging fraud schemes through the use of automated predictive modeling techniques; and

“(ii) improve the efficiency and effectiveness of current fraud and abuse detection methods by incorporating predictive risk scoring techniques that minimize investigations that result in false positive outcomes.”.

**SA 3003.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title III, insert the following:

**Subtitle —Better Diabetes Care**

**SEC. 1. SHORT TITLE.**

This subtitle may be cited as the “Catalyst to Better Diabetes Care Act of 2009”.

**SEC. 2. DIABETES SCREENING COLLABORATION AND OUTREACH PROGRAM.**

(a) ESTABLISHMENT.—With respect to diabetes screening tests and for the purposes of reducing the number of undiagnosed seniors with diabetes or prediabetes, the Secretary of Health and Human Services (referred to in this subtitle as the “Secretary”), in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall—

(1) review uptake and utilization of diabetes screening benefits to identify and address any existing problems with regard to utilization and data collection mechanisms;

(2) establish an outreach program to identify existing efforts by agencies and by the private and nonprofit sectors to increase awareness among seniors and providers of diabetes screening benefits; and

(3) maximize cost effectiveness in increasing utilization of diabetes screening benefits.

(b) CONSULTATION.—In carrying out this section, the Secretary and the Director shall consult with—

(1) various units of the Federal Government, including the Centers for Medicare & Medicaid Services, the Surgeon General of the Public Health Service, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the National Institutes of Health; and

(2) entities with an interest in diabetes, including industry, voluntary health organizations, trade associations, and professional societies.

**SEC. 3. ADVISORY GROUP REGARDING EMPLOYEE WELLNESS AND DISEASE MANAGEMENT BEST PRACTICES.**

(a) ESTABLISHMENT.—The Secretary shall establish an advisory group consisting of representatives of the public and private sector. The advisory group shall include—

(1) representatives of the Department of Health and Human Services;

(2) representatives of the Department of Commerce; and

(3) members of the public, representatives of the private sector, and representatives of

the small business community, who have experience with diabetes or in administering and operating employee wellness and disease management programs.

(b) DUTIES.—The advisory group established under subsection (a) shall examine and make recommendations of best practices of employee wellness and disease management programs in order to—

(1) provide public and private sector entities with improved information in assessing the role of employee wellness and disease management programs in saving money and improving quality of life for patients with chronic illnesses; and

(2) encourage the adoption of effective employee wellness and disease management programs.

(c) REPORT.—Not later than 1 year after the date of the enactment of this Act, the advisory group established under subsection (a) shall submit to the Secretary the results of the examination under subsection (b)(1).

**SEC. 4. NATIONAL DIABETES REPORT CARD.**

(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a “Report Card”) and, to the extent possible, for each State.

(b) CONTENTS.—

(1) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(A) preventative care practices and quality of care;

(B) risk factors; and

(C) outcomes.

(2) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

(A) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(B) informing policy and program development.

(c) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

**SEC. 5. IMPROVEMENT OF VITAL STATISTICS COLLECTION.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(1) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(2) encourage State adoption of the latest standard revisions of birth and death certificates; and

(3) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(b) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this section, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

**SEC. 6. STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.**

(a) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine

and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under subsection (a) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

**SEC. 7. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to carry out this subtitle such sums as may be necessary.

**SA 3004.** Mrs. HAGAN (for herself and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 32, after line 24, add the following: “(d) CLEAR TRANSPARENCY OF HEALTH CARE CHARGES.—

“(1) PUBLIC DISCLOSURE OF REIMBURSEMENT AMOUNTS.—A health insurance issuer offering group or individual health insurance coverage shall report at least once a year to the Secretary the current allowable reimbursement that the issuer will provide for all covered benefits and services (other than prescription medications dispensed through a licensed pharmacy), including—

“(A) with respect to services provided by in-network providers where payment is made in part or in full on a fee for service basis, the current allowed charge for specific services using currently accepted procedure coding associated with each provider; and

“(B) the expected reasonable and allowed charges made for services by out-of-network providers and the amount the issuer would reimburse for such charges.

“(2) ACCESSIBILITY.—Information submitted to the Secretary under paragraph (1) shall be maintained by the Secretary in a manner that ensures that such information is readily accessible by the public.

“(3) REGULATIONS.—Not later than one year after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to implement the requirements of this subsection.”.

**SA 3005.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 150, line 5, strike “small business development centers” and insert “resource partners of the Small Business Administration”.

**SA 3006.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1280, between lines 18 and 19, insert the following:

(VIII) small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)) and self-employed individuals; and

**SA 3007.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 163, between lines 21 and 22, insert the following:

(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

**SA 3008.** Ms. LANDRIEU (for herself, Ms. SNOWE, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. SMALL BUSINESS PROCUREMENT.**

Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.

**SA 3009.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces

and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 54, between lines 16 and 17, insert the following:

(F) ALLOCATION OF FUNDING FOR SMALL BUSINESSES.—Of the amount appropriated under subsection (e), a reasonable amount, as determined by the Secretary, shall be used to provide reimbursement to participating employment-based plans of small employers with 50 or fewer employees.

**SA 3013.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 55, line 4, strike “website,” and all that follows through line 5 on page 56 and insert the following: “website, through which a resident of, or small business in, any State may identify affordable health insurance coverage options in that State.

(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or  
(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

(B) Medicaid coverage under title XIX of the Social Security Act.

(C) Coverage under title XXI of the Social Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.”

**SA 3011.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 349, line 16, strike all through page 350, line 14.

**SA 3012.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) sub-

mitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 5 YEARS.**

(a) IN GENERAL.—Section 45R(e)(2) of the Internal Revenue Code of 1986, as added by section 1421(a), is amended by striking “2-consecutive-taxable year” and inserting “5-consecutive-taxable year”.

(b) CONFORMING AMENDMENT.—Section 45R(i) of the Internal Revenue Code of 1986, as so added, is amended by striking “2-year” and inserting “5-year”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 1421.

**SA 3013.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 274, after line 25, add the following:

**SEC. 90 . . . PARTIAL DEDUCTION FOR HEALTH INSURANCE COSTS IN COMPUTING SELF-EMPLOYMENT TAXES.**

(a) IN GENERAL.—Paragraph (4) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

“(4) REDUCED DEDUCTION FOR SELF-EMPLOYMENT TAX PURPOSES.—In determining an individual’s net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2, the deduction allowable by reason of this subsection shall be reduced by an amount equal to 50 percent of the amount which would otherwise be allowable (determined without regard to this paragraph).”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

**SA 3014.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 2010.**

(a) IN GENERAL.—Subsections (d)(3)(B)(i) and (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a),

is amended by striking “2011” each place it appears and inserting “2010, 2011”.

(b) CONFORMING AMENDMENTS.—

(1) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1), is amended by striking “2011” and inserting “2010, 2011”.

(2) Section 1421(f) is amended by striking “2010” both places it appears and inserting “2009”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 1421.

**SA 3015.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . PROTECTION OF ACCESS TO QUALITY HEALTH CARE THROUGH THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.**

(a) HEALTH CARE THROUGH DEPARTMENT OF VETERANS AFFAIRS.—Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize veterans and dependents eligible for health care through the Department of Veterans Affairs under the laws administered by the Secretary of Veterans Affairs from receiving timely access to quality health care in any facility of the Department or from any non-Department health care provider through which the Secretary provides health care.

(b) HEALTH CARE THROUGH DEPARTMENT OF DEFENSE.—

(1) IN GENERAL.—Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize eligible beneficiaries from receiving timely access to quality health care in any military medical treatment facility or under the TRICARE program.

(2) DEFINITIONS.—In this subsection:

(A) The term “eligible beneficiaries” means covered beneficiaries (as defined in section 1072(5) of title 10, United States Code) for purposes of eligibility for mental and dental care under chapter 55 of title 10, United States Code.

(B) The term “TRICARE program” has the meaning given that term in section 1072(7) of title 10, United States Code.

**SA 3016.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 246, between lines 7 and 8, insert the following:

“(C) SPECIAL RULES TO ENSURE CITIZENS AND NATIONALS OF THE UNITED STATES HAVE THE SAME HEALTH CARE CHOICES AS LEGAL IMMIGRANTS.—

“(i) IN GENERAL.—Notwithstanding any other provision of this Code, the Patient Protection and Affordable Care Act, or any

amendment made by that Act, any taxpayer who—

“(I) is a citizen or national of the United States; and

“(II) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved,

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security, or under a waiver of such plan.

“(ii) SPECIAL RULES.—

“(I) An individual making an election under clause (i) shall waive being provided with medical assistance under the State Medicaid plan under title XIX of the Social Security, or under a waiver of such plan while enrolled in a qualified health plan.

“(II) In the case of an individual who is a child, the child’s parent or legal guardian may make such an election on behalf of the child.

“(III) Any individual making such an election, or on whose behalf such an election is made, shall be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

**SA 3017.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of part I of subtitle C of title I, insert the following:

**SEC. 1202. APPLICATION OF WELLNESS PROGRAMS PROVISIONS TO CARRIERS PROVIDING FEDERAL EMPLOYEE HEALTH BENEFITS PLANS.**

(a) IN GENERAL.—Notwithstanding section 8906 of title 5, United States Code (including subsections (b)(1) and (b)(2) of such section), section 2705(j) of the Public Health Service Act (as added by section 1201) (relating to wellness programs) shall apply to carriers entering into contracts under section 8902 of title 5, United States Code.

(b) PROPOSALS.—Carriers may submit separate proposals relating to voluntary wellness program offerings as part of the annual call for benefit and rate proposals to the Office of Personnel Management.

(c) EFFECTIVE DATE.—This subsection shall take effect on the date of enactment of this Act and shall apply to contracts entered into under section 8902 of title 5, United States Code, that take effect with respect to calendar years that begin more than 1 year after that date.

**SA 3018.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . APPOINTMENT OF HEALTH CARE CZARS.**

Notwithstanding any other provision of this Act, any individual appointed by the President as a czar to handle health care issues shall be subject to Senate confirmation.

**SA 3019.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 100, line 16, insert “ or meets the requirements for a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986” after “section 1302(a)”.

**SA 3020.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . EQUIVALENT BANKRUPTCY PROTECTIONS FOR HEALTH SAVINGS ACCOUNTS AS RETIREMENT FUNDS.**

(a) IN GENERAL.—Section 522 of title 11, United States Code, is amended by adding at the end the following new subsection:

“(r) TREATMENT OF HEALTH SAVINGS ACCOUNTS.—For purposes of this section, any health savings account (as described in section 223 of the Internal Revenue Code of 1986) shall be treated in the same manner as an individual retirement account described in section 408 of such Code.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to cases commencing under title 11, United States Code, after the date of the enactment of this Act.

**SA 3021.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

**SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.**

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

benefits under title II of such Act as a condition for making such election.

**SA 3022.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

**SEC. . . . LIMITATION ON IMPLEMENTATION.**

Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall not implement the amendments made by and the provisions of this part for any year unless the Secretary certifies with respect to such year that such amendments and provisions will not result in any individual who would otherwise be enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act being forced away from or losing their enrollment in such plan, as such enrollment was in effect on the day before the date of enactment of this Act.

**SA 3023.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

**SEC. 3404. ENSURING MEDICARE SAVINGS ARE KEPT IN THE MEDICARE PROGRAM.**

No reduction in outlays under the Medicare program under title XVIII of the Social Security Act under the provisions of and amendments made by this Act may be utilized to offset any outlays under any other program or activity of the Federal government.

**SA 3024.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . . . PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS UNRELATED TO MEDICARE.**

Title III of the Congressional Budget Act of 1974 (2 U.S.C. 621 et seq.) is amended by adding at the end the following:

**"SEC. 316. PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS UNRELATED TO MEDICARE.**

"For purposes of this title and title IV, a reduction in outlays under title XVIII of the

Social Security Act may not be counted as an offset to any outlays under any other program or activity of the Federal Government."

**SA 3025.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1050, between lines 9 and 10, insert the following:

"(n) REDUCTIONS IN MEDICARE PROGRAM SPENDING NOT COUNTED TOWARDS THE PAY-AS-YOU-GO SCORECARD.—Any reductions in Medicare program spending enacted pursuant to this section shall not count towards the pay-as-you-go scorecard under section 201(a)(6) of S. Con. Res. 21 (110th Congress)."

**SA 3026.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2044, between lines 7 and 8, insert the following:

(d) ADDITIONAL HOSPITAL INSURANCE TAX SOLELY DEDICATED TO MEDICARE.—It is the policy of Congress that the additional hospital insurance taxes resulting from the amendments made by this section shall, as is the case regarding such taxes under the Social Security Act as in effect on the date of the enactment of this Act, be deposited into the Federal Hospital Insurance Trust Fund and under the terms of that Trust Fund used only for purposes of funding the Medicare program under part A of title XVIII of the Social Security Act.

**SA 3027.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. STATE OPTION TO OPT-OUT OF MEDICAID COVERAGE EXPANSION TO AVOID ASSUMING UNFUNDED FEDERAL MANDATE.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), the Governor of a State shall have the authority to opt out of any provision under this Act or any amendment made by this Act that requires the State to expand coverage under the Medicaid program if the State agency responsible for administering the State plan under title XIX certifies that such expansion would result in an increase of

at least 1 percent in the total amount of expenditures by the State for providing medical assistance to all individuals enrolled under the State plan, when compared to the total amount of such expenditures for the most recently ended State fiscal year.

**SA 3028.** Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . . . STUDY AND REPORT ON MEDICARE COVERAGE FOR MEDICAL EQUIPMENT USED IN THE TREATMENT OF CIRCULATORY DISEASES.**

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on the feasibility and advisability of providing for reimbursement under the Medicare program under title XVIII of the Social Security Act for gradient pumps and compression stockings that are used in the treatment of individuals with lymphedema, chronic venous insufficiency, and other circulatory diseases. Such study shall include an analysis of the following:

(1) The types of gradient pumps and compression stockings that are currently available on the market.

(2) The clinical appropriateness of providing gradient pumps and compression stockings for Medicare beneficiaries who have been diagnosed with lymphedema, chronic venous insufficiency, and other circulatory diseases.

(3) The financial impact on the Medicare program (including a description of any resulting costs or savings) if reimbursement were to be provided for gradient pumps and compression stockings that are used in the treatment of lymphedema, chronic venous insufficiency, and other circulatory diseases.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

**SA 3029.** Mr. THUNE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, between lines 19 and 20, insert the following:

"(f) LIMITATION.—A full-time employee shall not be taken into account for purposes of calculating the amount of any assessable payment imposed under subsections (a), (b), or (c) if such employee performs the majority of services in a State—

"(1) the unemployment rate of which exceeds 6 percent, and

"(2) the Governor of which has certified that the assessable penalties imposed under this section have contributed to such unemployment rate."

**SA 3030.** Mrs. FEINSTEIN (for herself, Mr. ROCKEFELLER, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 37, strike line 10 through line 14 and insert the following:

“(1) IN GENERAL.—

“(A) ESTABLISHMENT.—The Secretary, in conjunction with States, shall establish a uniform process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

“(B) ELECTRONIC REPORTING.—The process established under subparagraph (A) shall include an electronic reporting system established by the Secretary through which health insurance issuers shall report to the Secretary and State insurance commissioners the information requested by the Secretary pursuant to this subsection.

On page 37, between lines 24 and 25, insert the following:

“(3) HEALTH INSURANCE RATE AUTHORITY.—

“(A) IN GENERAL.—The Secretary shall establish a Health Insurance Rate Authority (referred to in this paragraph as the ‘Authority’) to be composed of 7 members to be appointed by the Secretary, of which—

“(i) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

“(ii) at least 1 member shall be an individual who is a medical professional;

“(iii) at least 1 member shall be a representative of health insurance issuers; and

“(iv) such remaining members shall be individuals who are recognized for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, and other related fields, who provide broad geographic representation and a balance between urban and rural members.

“(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning the Secretary’s duties under this subsection.

“(4) CORRECTIVE ACTION FOR UNJUSTIFIED RATE INCREASES.—

“(A) IN GENERAL.—Pursuant to the procedures set forth in this paragraph, the Secretary or the relevant State insurance commissioner shall—

“(i) review potentially unreasonable rate increases and determine whether such increases are justified; and

“(ii) take action to ensure that any rate increase found to be unjustified under clause (i) is corrected, through mechanisms including—

“(I) denial of the rate increase;

“(II) modification of the rate increase;

“(III) ordering rebates to consumers; or

“(IV) any other actions that correct for the unjustified increase.

“(B) REQUIRED REPORT.—The Secretary shall ensure that, not later than 6 months after the date of enactment of the Patient Protection and Affordable Care Act, the National Association of Insurance Commissioners (referred to in this section as the ‘Association’), in conjunction with States, or

other appropriate body, will provide to the Secretary and the Authority a report on—

“(i) State authority to review rates in each insurance market, and methodologies used in such reviews;

“(ii) rating requests received by the State in the previous 12 months and subsequent actions taken by States to approve, deny, or modify such requests; and

“(iii) justifications by insurance issuers for rate requests.

“(C) DETERMINATION OF WHO CONDUCTS REVIEWS FOR EACH STATE.—Using the report submitted pursuant to subparagraph (B), the Secretary shall determine not later than 1 year after the date of enactment of the Patient Protection and Affordable Care Act—

“(i) for which States the State insurance commissioner shall undertake the actions described in subparagraph (A)—

“(I) based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

“(II) as a condition of receiving a grant under subsection (c)(1); and

“(ii) for which States the Secretary shall undertake the actions described in subparagraph (A), based on the Secretary’s determination that such States lacks the authority and capability described in clause (i).

“(D) TRANSITION PERIOD.—Until the Secretary makes the determinations described in subparagraph (C), the relevant State insurance commissioner shall, as a condition of receiving a grant under subsection (c)(1), carry out the action described in subparagraph (A).

“(E) SUNSET.—Beginning on the date on which subsection (b)(2)(A) applies, the requirements of this paragraph shall no longer have force or effect.

“(5) PRIORITIZING PROPOSED PREMIUM INCREASES FOR REVIEW.—In determining which proposed premium increases to review under this subsection, the Secretary or the relevant State insurance commissioner may prioritize—

“(A) rate increases which exceed market averages;

“(B) rate increases that will impact large numbers of consumers; and

“(C) rate reviews requested from States, if applicable.

“(6) ANNUAL REPORT.—

“(A) UNIFORM DATA COLLECTION SYSTEM.—The Secretary, in consultation with the Association and the Authority, shall develop a uniform data collection system for rate information, which shall include information on rates, medical loss ratios, consumer complaints, solvency, reserves, and any other relevant factors of market conduct.

“(B) PREPARATION OF ANNUAL REPORT.—Using the data obtained in accordance with subparagraph (A), the Authority shall annually produce a single, aggregate report on insurance market behavior, which includes—

“(i) State-by-State information on rate increases from one year to the next, including by issuer and by market and including medical trends, benefit changes, and relevant demographic changes; and

“(ii) a national growth rate percentage for every issuer, which shall be based on aggregated data of such issuer from premiums sold in the each market.

“(C) DISTRIBUTION.—The Authority shall share the annual report described in subparagraph (B) with States, and include such report in the information disclosed to the public.

“(7) RECOMMENDATION ON EXCHANGE PARTICIPATION.—

“(A) IN GENERAL.—Based on the information provided pursuant to this subsection and other relevant information, the official

described in subparagraph (B) shall make recommendations to State Exchanges about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern of excessive premium increases, low medical loss ratios, or market conduct.

“(B) REVIEWING OFFICIAL.—Either the Secretary or the relevant State insurance commissioner or commissioners, based on the determination in paragraph (4)(C), shall make the recommendations described in subparagraph (A).

On page 144, line 12, strike “may” and insert “shall”.

**SA 3031.** Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

**SEC. 5510. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN’S HOSPITALS.**

Subpart IX of part D of title III of the Public Health Service Act (42 U.S.C. 256e et seq.) is amended—

(1) in the subpart heading, by adding “and Women’s Hospitals” at the end; and

(2) by adding at the end the following:

**“SEC. 340E-1. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN’S HOSPITALS.**

“(a) PAYMENTS.—The Secretary shall make two payments under this section to each women’s hospital for each of fiscal years 2010 through 2014, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.

“(b) AMOUNT OF PAYMENTS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amounts payable under this section to a women’s hospital for an approved graduate medical residency training program for a fiscal year shall be each of the following:

“(A) DIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for direct expenses associated with operating approved graduate medical residency training programs for a fiscal year.

“(B) INDIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs for a fiscal year.

“(2) CAPPED AMOUNT.—

“(A) IN GENERAL.—The total of the payments made to women’s hospitals under paragraph (1) in a fiscal year shall not exceed the funds appropriated under subsection (e) for such payments for that fiscal year.

“(B) PRO RATA REDUCTIONS OF PAYMENTS.—If the Secretary determines that the amount of funds appropriated under subsection (e) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

“(3) ANNUAL REPORTING REQUIRED.—The provisions of subsection (b)(3) of section 340E shall apply to women’s hospitals under this section in the same manner as such provisions apply to children’s hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women’s hospitals.

“(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 340E shall apply to women’s hospitals under this section in the same manner as such provisions apply to children’s hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women’s hospitals.

“(d) MAKING OF PAYMENTS.—

“(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 12 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital’s most recently filed Medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established. In the case of a hospital that does not report residents on a Medicare cost report, such interim payments shall be based on the number of residents trained during the hospital’s most recently completed Medicare cost report filing period.

“(2) WITHHOLDING.—The Secretary shall withhold up to 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1) as necessary to ensure a hospital will not be overpaid on an interim basis.

“(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made and pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1886(d) of such Act is subject to review under such section.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$12,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

“(f) DEFINITIONS.—In this section:

“(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term ‘approved graduate medical residency training program’ has the meaning given the term ‘approved medical residency training program’ in section 1886(h)(5)(A) of the Social Security Act.

“(2) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term ‘direct graduate medical education costs’ has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.

“(3) WOMEN’S HOSPITAL.—The term ‘women’s hospital’ means a hospital—

“(A) that has a Medicare provider agreement under title XVIII of the Social Security Act;

“(B) that has an approved graduate medical residency training program;

“(C) that has not been excluded from the Medicare prospective payment system;

“(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

“(E) with respect to which and as determined by the Centers for Medicare & Medicaid Services, less than 4 percent of the total discharges from the hospital during 2007 were Medicare discharges of individuals who, as of the time of the discharge—

“(i) were enrolled in the original Medicare fee-for-service program under part A of title XVIII of the Social Security Act; and

“(ii) were not enrolled in—

“(I) a Medicare Advantage plan under part C of title XVIII of that Act;

“(II) an eligible organization under section 1876 of that Act; or

“(III) a PACE program under section 1894 of that Act.”.

**SA 3032.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 36, strike line 23 and insert the following: “be necessary to carry out this section.

**“SEC. 2793A. IMPROVING OVERSIGHT OF INSURER SERVICE TO BENEFICIARIES.**

“(a) DEFINITIONS.—In this section—

“(1) the term ‘database’ means the database established under subsection (b); and

“(2) the term ‘NAIC’ means the National Association of State Insurance Commissioners.

“(b) MONITORING INSURER HANDLING OF REQUESTS FOR COVERAGE OF MEDICAL CARE.—

“(1) ESTABLISHMENT.—The Secretary shall, in consultation with the NAIC, establish and maintain a nationally consistent database that, using standardized definitions, tracks claims handling performance by—

“(A) all group health plans (and health insurance issuers offering group health insurance coverage in connection with a group health plan) and health insurance issuers that offer health insurance coverage in the individual market; and

“(B) external review organizations that consider and resolve external appeals from such plans and issuers.

“(2) CONTENT.—The database shall include information on the nature, timing, final disposal, and other relevant details (as determined by the Secretary) of claims, appeals, reviews, and requests for or denials of treatment by the entities described in paragraph (1). The Secretary may limit the content of the database to those claims that are monetarily significant, as determined by the Secretary.

“(3) COLLECTION OF DATA.—The Secretary shall have the authority to collect and audit data from entities described in paragraph (1) necessary to implement the database, except that, in the case of such plans and issuers subject to the Employee Retirement Income Security Act of 1974, such data shall be collected by the Secretary of Labor for use by the Secretary. At the discretion of the Secretary, such data collection authority may be delegated to State insurance regulators.

“(4) DATA PROTECTION AND PRIVACY.—The Secretary and the Secretary of Labor shall ensure the confidentiality and privacy of any claims data submitted pursuant to this section. Within 1 year of the date of enactment of this section, the Secretary shall promulgate a proposed regulation to ensure that such data is protected against any violation of the privacy and confidentiality of an individual’s medical records. Within 180 days of such promulgation, the Comptroller General shall publish a report on the adequacy of such regulation to ensure such protection. The database shall not include names, unencrypted Social Security numbers, addresses, or other information that may uniquely identify an individual.

“(5) TABULATION; CLASSIFICATION.—The Secretary shall work with the NAIC to develop a procedure for centralized tabulation and classification of consumer complaints related to claims handling, appeals, and reviews by the entities described in paragraph (1).

“(c) IMPLEMENTATION.—The Secretary shall implement the database not later than 2 years after the date of enactment of this section.

“(d) DISSEMINATION.—The Secretary shall make the database available to State insurance regulators, health exchanges, and consumer assistance ombudsmen, provided that such entities ensure the confidentiality and privacy of medical records and comply with all existing privacy laws, and shall update the database on a quarterly basis.

“(e) REPORTING.—Not later than January 1, 2013, and on an annual basis thereafter, the Secretary shall issue a public report assessing the performance of the plans and issuers described in subsection (b)(1)(A) regarding claims handling, appeals, and reviews. Such report shall assess whether there is any evidence of a pattern of denial or delay of medically necessary claims or appeals.”.

**SA 3033.** Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1133, between lines 22 and 23, insert the following:

**SEC. 3511. CONSISTENT QUALITY ACCREDITATION REQUIREMENTS FOR PROVIDERS CONTRACTING WITH MEDICARE ADVANTAGE PLANS AND STATE MEDICAID PROGRAMS.**

(a) MEDICARE ADVANTAGE.—Section 1854(a)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w-24(a)(6)(B)(iii)) is amended—

(1) by striking “In order to” and inserting the following:

“(aa) IN GENERAL.—In order to”; and

(2) by adding at the end the following:

“(bb) QUALITY ASSURANCE.—An MA organization shall not prohibit a particular hospital, physician or other entity within a category of healthcare providers from eligibility to contract with the MA organization because of a separate policy of the MA organization that does not recognize an approved nationally recognized accreditation organization with the appropriate ‘deeming authority’ from the Secretary.”.

(b) STATE MEDICAID PLAN REQUIREMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a(a)(23)) is amended by inserting “and (C) the State plan and a primary

care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not prohibit a particular hospital, physician or other entity within a category of healthcare providers from being qualified to perform a service or services because of a separate policy of the State plan, system, organization, or entity that does not recognize an approved nationally recognized accreditation organization with the appropriate 'deeming authority' from the Secretary" after "subsection (g) and in section 1915".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and, in the case of MA organizations under part C of title XVIII of the Social Security Act, apply to plan years beginning after that date.

**SA 3034.** Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 828, between lines 3 and 4, insert the following:

**SEC. 3130. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM FOR RURAL ENTITIES.**

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after section 1602 the following:

**"SEC. 1603. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM FOR RURAL ENTITIES.**

"(a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

"(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

"(A) the acquisition of software and hardware necessary to implement electronic health records as required under section 3011;

"(B) the acquisition of land necessary for the capital improvements;

"(C) the renovation or modernization of any building;

"(D) the acquisition or repair of fixed or major movable equipment; and

"(E) such other project expenses as the Secretary determines appropriate.

"(2) AUTHORITY TO GUARANTEE LOANS.—

"(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

"(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

"(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed \$2,500,000.

"(c) FUNDING LIMITATIONS.—

"(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Federal Credit Reform Act of 1990 scoring protocol with re-

spect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed \$50,000,000 per year.

"(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed \$400,000,000 per year.

"(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

"(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed \$50,000, for purposes of capital assessment and business planning.

"(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed \$2,500,000 per year.

"(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2013."

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s-3) is amended by adding at the end the following:

"(15)(A) The term 'rural entity' includes—

"(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

"(ii) any medical facility with at least 1 bed, but not more than 49 beds, that is located in—

"(I) a county that is not part of a metropolitan statistical area; or

"(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)); and

"(iii) a hospital that is classified as a critical access hospital or a rural hospital with fewer than 1,500 discharges per year.

"(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the Medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A)."

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q-2) is amended—

(1) in subsection (b)(2)(D), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)"; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking "section 1601(a)(2)(B)" and inserting "sections 1601(a)(2)(B) and 1603(a)(2)(B)"; and

(B) in paragraph (2)(A), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)".

**SA 3035.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . . . HEALTH CARE SAFETY NET ENHANCEMENT.**

(a) LIMITATION ON LIABILITY.—Notwithstanding any other provision of law, a health care professional shall not be liable in any medical malpractice lawsuit for a cause of action arising out of the provision of, or the

failure to provide, any medical service to a medically underserved or indigent individual while engaging in the provision of pro bono medical services.

(b) REQUIREMENTS.—Subsection (a) shall not apply—

(1) to any act or omission by a health care professional that is outside the scope of the services for which such professional is deemed to be licensed or certified to provide, unless such act or omission can reasonably be determined to be necessary to prevent serious bodily harm or preserve the life of the individual being treated;

(2) if the services on which the medical malpractice claim is based did not arise out of the rendering of pro bono care for a medically underserved or indigent individual; or

(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.

(c) DEFINITION.—In this section—

(1) the term "medically underserved individual" means an individual who does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program; and

(2) the term "indigent individual" means and individual who is unable to pay for the health care services that are provided to the individual.

**SA 3036.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . . . DISASTER VOLUNTEER HEALTH CARE PROFESSIONAL PROTECTION.**

(a) LIMITATION ON LIABILITY.—Notwithstanding any other provision of law, with respect to an area in which a major disaster has been declared in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5721 et seq.), a health care professional who is providing health or dental services on a voluntary basis in such area, or to a non-resident victim of the disaster involved, shall not be liable for damages in a medical malpractice lawsuit for a cause of action arising out of an act or omission of such professional in providing the services involved.

(b) REQUIREMENTS.—Subsection (a) shall not apply—

(1) to any act or omission by a health care professional that is outside the scope of the services for which such professional is deemed to be licensed or certified to provide, unless such act or omission can reasonably be determined to be necessary to prevent serious bodily harm or preserve the life of the individual being treated;

(2) if the services on which the medical malpractice claim is based did not arise out of the rendering of voluntary care in the disaster area or were provided to an individual who was not a victim of the disaster; or

(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.

(c) LIMITATION ON VICARIOUS LIABILITY.—An individual or a health care institution that deploys or uses a volunteer described in subsection (a) shall not be vicariously liable in a medical malpractice lawsuit with respect to services described in such subsection unless the volunteer involved is determined to be liable.

(d) RECIPROCITY WITH RESPECT TO LICENSED OR CERTIFIED HEALTH CARE PROFESSIONALS.—A health care professional that is licensed or certified in a State and who is providing health or dental services on a voluntary basis in an area in which a major disaster has been declared in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5721 et seq.), shall be deemed to be licensed or certified by the State in which such area is located with respect to such health or dental services, subject to any additional conditions, limitations, or expansions that may be applied by the chief executive of the State in which such area is located.

**SA 3037.** Mr. JOHNSON (for himself, Mr. FRANKEN, Mr. BURRIS, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 731, between lines 16 and 17, insert the following:

“(xix) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b-1 note).

**SA 3038.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. EXTENSION OF ARRA INCREASE IN FMAP.**

Section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is amended—

(1) in subsection (a)(3), by striking “first calendar quarter” and inserting “first 3 calendar quarters”;

(2) in subsection (b)(2), by inserting before the period at the end the following: “, and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010”;

(3) in subsection (c)(4)(C)(ii), by striking “December 2009” and “January 2010” and inserting “June 2010” and “July 2010”, respectively;

(4) in subsection (d), by inserting “ending before October 1, 2010” after “entire fiscal

years” and after “with respect to fiscal years”;

(5) in subsection (g)(1), by striking “September 30, 2011” and inserting “December 31, 2011”;

(6) in subsection (h)(3), by striking “December 31, 2010” and inserting “June 30, 2011”.

**SA 3039.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. MANAGED CARE ORGANIZATIONS.**

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) by striking “and” at the end of clause (xi);

(B) by striking the period at the end of clause (xii) and inserting “; and”; and

(C) by adding at the end the following new clause:

“(xiii) such contract has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary, that is a percentage (not less than 85 percent) specified by the Secretary.”

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 2101(d)(2), 2101(e), and 6401(c), is amended—

(A) by redesignating subparagraphs (H) through (O) as subparagraphs (I) through (P); and

(B) by inserting after subparagraph (G) the following new subparagraph:

“(H) Section 1903(m)(2)(A)(xiv) (relating to application of minimum loss ratios), with respect to comparable contracts under this title.”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting “and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary” after “patients”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

**SA 3040.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. AUTOMATIC INCREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN.**

(a) NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, 4106(b), and 4107, is amended—

(A) in subsection (b), in the first sentence—

(i) by striking “and (5)” and inserting “(5)”;

(ii) by inserting “and (6) with respect to each fiscal year quarter other than the first quarter of a national economic downturn assistance period described in subsection (cc)(1), the Federal medical assistance percentage for any State described in subsection (cc)(2) shall be equal to the national economic downturn assistance FMAP determined for the State for the quarter under subsection (cc)(3)” before the period; and

(B) by adding at the end the following: “(cc) NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—For purposes of clause (6) of the first sentence of subsection (b):

“(1) NATIONAL ECONOMIC DOWNTURN ASSISTANCE PERIOD.—A national economic downturn assistance period described in this paragraph—

“(A) begins with the first fiscal year quarter for which the Secretary determines that for at least 23 States, the rolling average unemployment rate for that quarter has increased by at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available (in this subsection referred to as the ‘trigger quarter’); and

“(B) ends with the first succeeding fiscal year quarter for which the Secretary determines that less than 23 States have a rolling average unemployment rate for that quarter with an increase of at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available.

“(2) ELIGIBLE STATE.—A State described in this paragraph is a State for which the Secretary determines that the rolling average unemployment rate for the State for any quarter occurring during a national economic downturn assistance period described in paragraph (1) has increased over the corresponding quarter for the most recent preceding 12-month period for which data are available.

“(3) DETERMINATION OF NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

“(A) IN GENERAL.—The national economic downturn assistance FMAP for a fiscal year quarter determined with respect to a State under this paragraph is equal to the Federal medical assistance percentage for the State for that quarter increased by the number of percentage points determined by—

“(i) dividing—

“(I) the Medicaid additional unemployed increased cost amount determined under subparagraph (B) for the quarter; by

“(II) the State’s total Medicaid quarterly spending amount determined under subparagraph (C) for the quarter; and

“(ii) multiplying the quotient determined under clause (i) by 100.

“(B) MEDICAID ADDITIONAL UNEMPLOYED INCREASED COST AMOUNT.—For purposes of subparagraph (A)(i)(I), the Medicaid additional unemployed increased cost amount determined under this subparagraph with respect to a State and a quarter is the product of the following:

“(i) STATE INCREASE IN ROLLING AVERAGE NUMBER OF UNEMPLOYED INDIVIDUALS FROM THE BASE QUARTER OF UNEMPLOYMENT.—

“(I) IN GENERAL.—The amount determined by subtracting the rolling average number of

unemployed individuals in the State for the base unemployment quarter for the State determined under subclause (II) from the rolling average number of unemployed individuals in the State for the quarter.

“(II) BASE UNEMPLOYMENT QUARTER DEFINED.—

“(aa) IN GENERAL.—For purposes of subclause (I), except as provided in item (bb), the base quarter for a State is the quarter with the lowest rolling average number of unemployed individuals in the State in the 12-month period preceding the trigger quarter for a national economic downturn assistance period described in paragraph (1).

“(bb) EXCEPTION.—If the rolling average number of unemployed individuals in a State for a quarter occurring during a national economic downturn assistance period described in paragraph (1) is less than the rolling average number of unemployed individuals in the State for the base quarter determined under item (aa), that quarter shall be treated as the base quarter for the State for such national economic downturn assistance period.

“(ii) NATIONAL AVERAGE AMOUNT OF ADDITIONAL FEDERAL MEDICAID SPENDING PER ADDITIONAL UNEMPLOYED INDIVIDUAL.—In the case of—

“(I) a calendar quarter occurring in fiscal year 2012, \$350; and

“(II) a calendar quarter occurring in any succeeding fiscal year, the amount applicable under this clause for calendar quarters occurring during the preceding fiscal year, increased by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

“(iii) STATE NONDISABLED, NONELDERLY ADULTS AND CHILDREN MEDICAID SPENDING INDEX.—

“(I) IN GENERAL.—With respect to a State, the quotient (not to exceed 1.00) of—

“(aa) the State expenditure per person in poverty amount determined under subclause (II); divided by—

“(bb) the National expenditure per person in poverty amount determined under subclause (III).

“(II) STATE EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I)(aa), the State expenditure per person in poverty amount is the quotient of—

“(aa) the total amount of annual expenditures by the State for providing medical assistance under the State plan to nondisabled, nonelderly adults and children; divided by

“(bb) the total number of nonelderly adults and children in poverty who reside in the State, as determined under paragraph (4)(A).

“(III) NATIONAL EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I)(bb), the National expenditure per person in poverty amount is the quotient of—

“(aa) the sum of the total amounts determined under subclause (II)(aa) for all States; divided by

“(bb) the sum of the total amounts determined under subclause (II)(bb) for all States.

“(C) STATE'S TOTAL MEDICAID QUARTERLY SPENDING AMOUNT.—For purposes of subparagraph (A)(i)(II), the State's total Medicaid quarterly spending amount determined under this subparagraph with respect to a State and a quarter is the amount equal to—

“(i) the total amount of expenditures by the State for providing medical assistance under the State plan to all individuals enrolled in the plan for the most recent fiscal year for which data is available; divided by

“(ii) 4.

“(4) DATA.—In making the determinations required under this subsection, the Secretary shall use, in addition to the most recent

available data from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State referred to in paragraph (5), the most recently available—

“(A) data from the Bureau of the Census with respect to the number of nonelderly adults and children who reside in a State described in paragraph (2) with family income below the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved (or, if the Secretary determines it appropriate, a multiyear average of such data);

“(B) data reported to the Secretary by a State described in paragraph (2) with respect to expenditures for medical assistance under the State plan under this title for non-disabled, nonelderly adults and children; and

“(C) econometric studies of the responsiveness of Medicaid enrollments and spending to changes in rolling average unemployment rates and other factors, including State spending on certain Medicaid populations.

“(5) DEFINITION OF ‘ROLLING AVERAGE NUMBER OF UNEMPLOYED INDIVIDUALS’, ‘ROLLING AVERAGE UNEMPLOYMENT RATE’.—In this subsection, the term—

“(A) ‘rolling average number of unemployed individuals’ means, with respect to a calendar quarter and a State, the average of the 12 most recent months of seasonally adjusted unemployment data for each State;

“(B) ‘rolling average unemployment rate’ means, with respect to a calendar quarter and a State, the average of the 12 most recent monthly unemployment rates for the State; and

“(C) ‘monthly unemployment rate’ means, with respect to a State, the quotient of—

“(i) the monthly seasonally adjusted number of unemployed individuals for the State; divided by

“(ii) the monthly seasonally adjusted number of the labor force for the State,

using the most recent data available from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State,

“(6) INCREASE IN CAP ON PAYMENTS TO TERRITORIES.—With respect to any fiscal year quarter for which the national economic downturn assistance Federal medical assistance percentage applies to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, the amounts otherwise determined for such commonwealth or territory under subsections (f) and (g) of section 1108 shall be increased by such percentage of such amounts as the Secretary determines is equal to twice the average increase in the national economic downturn assistance FMAP determined for all States described in paragraph (2) for the quarter.

“(7) SCOPE OF APPLICATION.—The national economic downturn assistance FMAP shall only apply for purposes of payments under section 1903 for a quarter and shall not apply with respect to—

“(A) disproportionate share hospital payments described in section 1923;

“(B) payments under title IV or XXI; or

“(C) any payments under this title that are based on the enhanced FMAP described in section 2105(b).

“(8) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State described in paragraph (2) that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under section 1902(a)(2), the State shall not require that such political subdivisions pay for any fiscal year quarters occurring during a national economic downturn assistance period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentage that would have been re-

quired by the State under State law in effect on the first day of the fiscal year quarter occurring immediately prior to the trigger quarter for the period.”

(2) EFFECTIVE DATE; NO RETROACTIVE APPLICATION.—The amendments made by paragraph (1) take effect on January 1, 2012. In no event may a State receive a payment on the basis of the national economic downturn assistance Federal medical assistance percentage determined for the State under section 1905(cc)(3) of the Social Security Act for amounts expended by the State prior to January 1, 2012.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall analyze the previous periods of national economic downturn, including the most recent such period in effect as of the date of enactment of this Act, and the past and projected effects of temporary increases in the Federal medical assistance percentage under the Medicaid program with respect to such periods.

(2) REPORT.—Not later than April 1, 2011, the Comptroller General of the United States shall submit a report to Congress on the results of the analysis conducted under paragraph (1). Such report shall include such recommendations as the Comptroller General determines appropriate for modifying the national economic downturn assistance FMAP established under section 1905(cc) of the Social Security Act (as added by subsection (a)) to improve the effectiveness of the application of such percentage in addressing the needs of States during periods of national economic downturn, including recommendations for—

(A) improvements to the factors that begin and end the application of such percentage;

(B) how the determination of such percentage could be adjusted to address State and regional economic variations during such periods; and

(C) how the determination of such percentage could be adjusted to be more responsive to actual Medicaid costs incurred by States during such periods, as well as to the effects of any other specific economic indicators that the Comptroller General determines appropriate.

**SA 3041.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 397, beginning on line 2, strike “under” and all that follows through line 6, and insert “not pregnant and are”

**SA 3042.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 553, between lines 14 and 15, insert the following:

**SEC. 2708. EVALUATION OF STATE COMPLIANCE WITH PROVISION OF COMMUNITY-BASED SERVICES TO INDIVIDUALS WITH DISABILITIES.**

Not later than December 31, 2010, and annually thereafter, the Inspector General of the Department of Justice shall prepare and submit a report to Congress that evaluates the adequacy of efforts by States to provide appropriate home and community-based services to individuals with disabilities in accordance with the requirements under *Olmstead v. L.C.*, 527 U.S. 581 (1999).

**SA 3043.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 397, strike line 15 and all that follows through page 398, line 25.

**SA 3044.** Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . PAYMENT OF MEDICARE LIABILITY TO STATES AS A RESULT OF THE SPECIAL DISABILITY WORKLOAD PROJECT.**

(a) IN GENERAL.—The Secretary, in consultation with the Commissioner, shall work with each State to reach an agreement, not later than 6 months after the date of enactment of this Act, on the amount of a payment for the State related to the Medicare program liability as a result of the Special Disability Workload project, subject to the requirements of subsection (c).

(b) PAYMENTS.—

(1) DEADLINE FOR MAKING PAYMENTS.—Not later than 30 days after reaching an agreement with a State under subsection (a), the Secretary shall pay the State, from the amounts appropriated under paragraph (2), the payment agreed to for the State.

(2) APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there is appropriated \$4,000,000,000 for fiscal year 2010 for making payments to States under paragraph (1).

(3) LIMITATIONS.—In no case may the aggregate amount of payments made by the Secretary to States under paragraph (1) exceed \$4,000,000,000.

(c) REQUIREMENTS.—The requirements of this subsection are the following:

(1) FEDERAL DATA USED TO DETERMINE AMOUNT OF PAYMENTS.—The amount of the payment under subsection (a) for each State is determined on the basis of the most recent Federal data available, including the use of proxies and reasonable estimates as necessary, for determining expeditiously the amount of the payment that shall be made to each State that enters into an agreement under this section. The payment methodology shall consider the following factors:

(A) The number of SDW cases found to have been eligible for benefits under the

Medicare program and the month of the initial Medicare program eligibility for such cases.

(B) The applicable non-Federal share of expenditures made by a State under the Medicaid program during the time period for SDW cases.

(C) Such other factors as the Secretary and the Commissioner, in consultation with the States, determine appropriate.

(2) CONDITIONS FOR PAYMENTS.—A State shall not receive a payment under this section unless the State—

(A) waives the right to file a civil action (or to be a party to any action) in any Federal or State court in which the relief sought includes a payment from the United States to the State related to the Medicare liability under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of the Special Disability Workload project; and

(B) releases the United States from any further claims for reimbursement of State expenditures as a result of the Special Disability Workload project (other than reimbursements being made under agreements in effect on the date of enactment of this Act as a result of such project, including payments made pursuant to agreements entered into under section 1616 of the Social Security Act or section 211(1)(1)(A) of Public Law 93-66).

(3) NO INDIVIDUAL STATE CLAIMS DATA REQUIRED.—No State shall be required to submit individual claims evidencing payment under the Medicaid program as a condition for receiving a payment under this section.

(4) INELIGIBLE STATES.—No State that is a party to a civil action in any Federal or State court in which the relief sought includes a payment from the United States to the State related to the Medicare liability under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of the Special Disability Workload project shall be eligible to receive a payment under this section while such an action is pending or if such an action is resolved in favor of the State.

(d) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term “Commissioner” means the Commissioner of Social Security.

(2) MEDICAID PROGRAM.—The term “Medicaid program” means the program of medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.) and includes medical assistance provided under any waiver of that program approved under section 1115 or 1915 of such Act (42 U.S.C. 1315, 1396n) or otherwise.

(3) MEDICARE PROGRAM.—The term “Medicare program” means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(5) SDW CASE.—The term “SDW case” means a case in the Special Disability Workload project involving an individual determined by the Commissioner to have been eligible for benefits under title II of the Social Security Act (42 U.S.C. 401 et seq.) for a period during which such benefits were not provided to the individual and who was, during all or part of such period, enrolled in a State Medicaid program.

(6) SPECIAL DISABILITY WORKLOAD PROJECT.—The term “Special Disability Workload project” means the project described in the 2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, H.R. Doc. No. 110-104, 110th Cong. (2008).

(7) STATE.—The term “State” means each of the 50 States and the District of Columbia.

**SEC. . REQUIREMENTS FOR MEDICAID PROVIDERS TO ACCEPT IN-NETWORK PAYMENT RATES FOR SERVICES PROVIDED TO MEDICAID MANAGED CARE ENROLLEES.**

(a) IN GENERAL.—Section 1932(b) of the Social Security Act (42 U.S.C. 1396u-2(b)) is amended by adding at the end the following

“(9) ASSURING ACCESS TO SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.—Any provider of items or services for which medical assistance is provided under the State plan or under a waiver of the plan that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for items or services furnished to a beneficiary enrolled in the entity’s Medicaid managed care plan shall accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2010.

**SA 3045.** Mr. KERRY (for himself, Mr. KIRK, Mr. SCHUMER, Mrs. GILLIBRAND, Mr. LEAHY, Mr. SANDERS, Mr. CARPER, and Mr. KAUFMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 402, strike line 15 and all that follows through page 403, line 9, and insert the following:

“(A) NEWLY ELIGIBLE.—The term “newly eligible” means an individual described in subclause (VIII) of section 1902(a)(10)(A)(i) who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan for full benefits or for benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

**SA 3046.** Mr. KERRY (for himself, Ms. STABENOW, Ms. COLLINS, Ms. SNOWE, Mr. WYDEN, Mrs. LINCOLN, Mr. JOHNSON, Mr. SPECTER, and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which

was ordered to lie on the table; as follows:

Beginning on page 983, strike line 11 and all that follows through page 984, line 3, and insert the following:

“(vi) PRODUCTIVITY ADJUSTMENT.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage, for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.”.

**SA 3047.** Mr. KERRY (for himself, Mr. WYDEN, Mr. WHITEHOUSE, Mr. REED) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.**

(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the administration, within the homes of Medicare beneficiaries, of intravenous immune globin for the treatment of primary immune deficiency diseases.

(b) DURATION AND SCOPE.—

(1) DURATION.—Beginning not later than January 1, 2011, the Secretary shall conduct the demonstration project for a period of 3 years.

(2) SCOPE.—The Secretary shall enroll not greater than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency disease for participation in the demonstration project. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time.

(c) REIMBURSEMENT.—The Secretary shall establish an hourly rate for payment for items and services needed for the administration of intravenous immune globin based on the low-utilization payment adjustment under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(d) STUDY AND REPORT TO CONGRESS.—

(1) INTERIM EVALUATION AND REPORT.—Not later than 24 months after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains the following:

(A) An interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k et seq.).

(C) An analysis of the feasibility of reducing the lag time with respect to data used to determine the average sales price under section 1847A of the Social Security Act (42 U.S.C. 1395w-3a).

(D) An update to the report entitled “Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)”, issued in February 2007 by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(2) FINAL EVALUATION AND REPORT.—Not later than July 1, 2014, the Secretary shall submit to Congress a report that contains a final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(e) OFFSET.—

(1) IN GENERAL.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following: “Such term includes disposable drug delivery systems, including elastomeric infusion pumps, for the treatment of colorectal cancer.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items furnished on or after the date of enactment of this Act.

(f) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term “demonstration project” means the demonstration project conducted under this section.

(2) MEDICARE BENEFICIARY.—The term “Medicare beneficiary” means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title.

(3) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

**SA 3048.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 172, between lines 11 and 12, insert the following:

(E) REPAYMENT OF FUNDS.—A person that receives Federal funds under a loan or grant under this section shall be required to reimburse the Federal Government for the full amount received under such loan or grant on terms established by the Secretary, but in no event shall such repayment be made later than 10 years after the date on which such loan or grant was made.

**SA 3049.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. PROTECTION OF MEDICAID WAIVER AUTHORITY.**

No provision of this Act or any amendment made by this Act shall limit or otherwise restrict any authority in effect on the date of enactment of this Act which the Secretary of Health and Human Services may exercise under section 1915 or 1115 of the Social Security Act or otherwise to encourage States to develop innovation programs to provide health insurance to uninsured individuals or to contain health care costs by granting States budget neutral Medicaid waivers Any provision of this Act or an amendment of this Act that is contrary to the preceding sentence is null and void.

**SA 3050.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1998, strike lines 13 through 24.

**SA 3051.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

**SEC. 3115. RURAL HEALTH CLINIC REIMBURSEMENT.**

Section 1833(f) of the Social Security Act (42 U.S.C. 1395l(f)) is amended—

(1) in paragraph (1), by striking “, and” at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking “in a subsequent year” and inserting “after 1988 and before 2010”; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

“(3) in 2010, at \$85 per visit; and

“(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.”.

**SA 3052.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

**SEC. 4403. RURAL HEALTH CLINIC AND COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.**

Section 330 of the Public Health Service Act (42 U.S.C. 254b), as amended by section 4206, is amended by adding at the end the following:

“(t) **RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.**—

“(1) **IN GENERAL.**—Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

“(2) **ASSURANCES.**—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

“(A) nondiscrimination based upon the ability of a patient to pay; and

“(B) the establishment of a sliding fee scale for low-income patients.”.

**SA 3053.** Mr. INHOFE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2026, strike line 3 and insert the following:

(i) **EXCLUSION OF ASSISTIVE DEVICES FOR PEOPLE WITH DISABILITIES.**—

(1) **IN GENERAL.**—The term “medical device sales” shall not include sales of any assistive device for people with disabilities.

(2) **REDUCTION OF AGGREGATE FEE AMOUNT.**—The \$2,000,000,000 amount in subsection (b)(1) shall be reduced in each calendar year by the amount which bears the same ratio to such \$2,000,000,000 amount as the amount of the sales of devices described in paragraph (1) for such calendar year bears to the amount of total medical device sales (without regard to this subsection) for such calendar year, as determined by the Secretary.

(j) **APPLICATION OF SECTION.**—This section shall

**SA 3054.** Mr. ROBERTS (for himself and Mr. KYL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1703, between lines 4 and 5, insert the following:

**SEC. 6303. PROHIBITION ON THE USE OF COST IN COMPARATIVE EFFECTIVENESS RESEARCH.**

(a) **IN GENERAL.**—Notwithstanding any other provision of law, in no case may the

cost of any medical treatment, item, or service described in subsection (b) be considered a factor in any comparative effectiveness research conducted—

(1) by the Federal Government; or

(2) by any other entity using funding provided by the Federal Government.

(b) **MEDICAL TREATMENT, ITEM, OR SERVICE.**—The medical treatments, services, and items described in this subsection are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(c) **INCLUSION.**—The comparative effectiveness research described under subsection (a) includes any such research conducted or funded by—

(1) the Patient-Centered Outcomes Research Institute under section 1181 of the Social Security Act (as added by section 6301);

(2) the Department of Health and Human Services, including the Agency for Healthcare Research and Quality and the National Institutes of Health; and

(3) the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b-8).

(d) **APPLICATION.**—This section shall apply to any comparative effectiveness research—

(1) that is ongoing as of the date of enactment of this Act; or

(2) that is conducted after the date of enactment of this Act.

**SA 3055.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1983, strike lines 1–11 and insert the following:

“(II) the 3-year average FEHB program premium increase for such year.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

(iv) **3-YEAR AVERAGE FEHB PROGRAM PREMIUM INCREASE.**—For purposes of clause (iii)—

(I) **IN GENERAL.**—The term “3-year average FEHB program premium increase” means, with respect to any calendar year, the average of the FEHB program premium increases for the preceding 3 calendar years.

(II) **FEHB PREMIUM INCREASE.**—The term “FEHB program premium increase” means, with respect to any calendar year, the average amount of the increases in premiums (if any) for all plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code, which were offered under such program for the preceding calendar year.

**SA 3056.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 340, strike lines 1 through 14 and insert the following:

“(A) **WAIVER OF CRIMINAL AND CIVIL PENALTIES AND INTEREST.**—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section—

“(i) such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure, and

“(ii) no penalty, addition to tax, or interest shall be imposed with respect to such failure or such penalty.

“(B) **LIMITED COLLECTION ACTIONS PERMITTED.**—In the case of the assessment of any penalty imposed by this section, the Secretary shall not take any action with respect to the collection of such penalty other than—

“(i) giving notice and demand for such penalty under section 6303,

“(ii) crediting under section 6402(a) the amount of any overpayment of the taxpayer against such penalty, and

“(iii) offsetting any payment owed by any Federal agency to the taxpayer against such penalty under the Treasury offset program.”.

**SA 3057.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 334, line 19, strike all through page 335, line 2, and insert the following:

“(2) **MIDDLE INCOME INDIVIDUALS AND FAMILIES.**—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than \$200,000 (\$250,000 in the case of a joint return), determined in the same manner as under subsection (c)(4).

**SA 3058.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. \_\_\_\_\_ . NO FEDERAL TAX INCREASE IMPOSED ON MIDDLE INCOME INDIVIDUALS AND FAMILIES.**

(a) **IN GENERAL.**—Notwithstanding any provision of, or amendment made by this Act, no such provision or amendment which, directly or indirectly, results in a Federal tax increase shall be administered in such manner as to impose such an increase on any middle income taxpayer.

(b) **MIDDLE INCOME TAXPAYER.**—For purposes of this section, the term “middle income taxpayer” means, for any taxable year,

any taxpayer with adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) of less than \$200,000 (\$250,000 in the case of a joint return of tax).

**SA 3059.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 1 through 20.

**SA 3060.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 9004.

**SA 3061.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. TAXES NOT FEES, PENALTIES, OR ASSESSABLE PAYMENTS.**

(a) TAXES NOT FEES.—Sections 4375, 4376, 4377, and 9511 of the Internal Revenue Code of 1986 (as added by section 6301(e)) and sections 9008, 9009, and 9010 are each amended by striking “fee” or “fees” each place they appear and inserting “tax” or “taxes”, respectively.

(b) TAXES NOT PENALTIES.—Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)) is amended by striking “penalty” each place it appears (other than the second place in paragraphs (1) and (2)(A) of subsection (g) thereof) and inserting “tax”.

(c) TAXES NOT ASSESSABLE PAYMENTS.—Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513(a)) and section 1513(c)(1) are each amended by striking “assessable payment” or “assessable payments” each place they appear and inserting “tax” or “taxes”, respectively.

**SA 3062.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other

purposes; which was ordered to lie on the table; as follows:

On page 357, strike line 15 and insert the following:

(d) REPORT ON IMPACT OF PENALTIES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the assessable payments imposed under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The report submitted under this subsection shall include a detailed analysis of the impact of such assessable penalty on—

(1) employer profits,  
(2) Federal revenues, including any decrease in tax revenues due to any decrease in employer profits as a result of such assessable penalties,  
(3) the level of wages and benefits of employees,  
(4) the hours worked by employees, including whether employees are classified as part-time or full-time employees, and  
(5) the termination of employees.

(e) EFFECTIVE DATE.—The amendments made by

\_\_\_\_\_

**SA 3063.** Mr. AKAKA (for himself and Mr. INOUE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 515 of the amendment, between lines 11 and 12, insert the following:

**SEC. 2552. ESTABLISHMENT OF PERMANENT MEDICAID DSH ALLOTMENT FOR HAWAII.**

(a) IN GENERAL.—Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r-4(f)(6)) is amended—

(1) by striking the paragraph heading and inserting the following: “ALLOTMENT ADJUSTMENTS FOR TENNESSEE AND HAWAII”; and

(2) in subparagraph (B), by adding at the end the following:

“(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

“(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

“(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clauses (i) and (iii) of paragraph (5)(B).

“(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary deter-

mines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.”.

(b) CONFORMING AMENDMENT.—Effective October 1, 2011, paragraph (7) of section 1923(f) of such Act (42 U.S.C. 1396r-4(f)), as added by section 2551, is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (E)” and inserting “subparagraphs (E) and (G)”; and

(2) by adding at the end the following: “(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).”.

**SA 3064.** Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 124, between lines 16 and 17, insert the following:

(4) NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.—

(A) NONDISCRIMINATION.—A Federal agency or program, and any State or local government that receives Federal financial assistance under this Act (or an amendment made by this Act), may not—

(i) subject any individual or institutional health care entity to discrimination; or

(ii) require any health plan created or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination,

on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(B) DEFINITION.—In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(C) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

**SA 3065.** Mr. CARDIN (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 396, between lines 8 and 9, insert the following:

**Subtitle H—Patient Protections****PART I—IMPROVING MANAGED CARE****Subpart A—Utilization Review; Claims****SEC. 1601. UTILIZATION REVIEW ACTIVITIES.****(a) COMPLIANCE WITH REQUIREMENTS.—**

(1) **IN GENERAL.**—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 1602.

(2) **USE OF OUTSIDE AGENTS.**—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) **UTILIZATION REVIEW DEFINED.**—For purposes of this section, the terms “utilization review” and “utilization review activities” mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

**(b) WRITTEN POLICIES AND CRITERIA.—**

(1) **WRITTEN POLICIES.**—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

**(2) USE OF WRITTEN CRITERIA.—**

(A) **IN GENERAL.**—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) **CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.**—If a health care service has been specifically pre-authorized or approved for a participant, beneficiary, or enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) **REVIEW OF SAMPLE OF CLAIMS DENIALS.**—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

**(c) CONDUCT OF PROGRAM ACTIVITIES.—**

(1) **ADMINISTRATION BY HEALTH CARE PROFESSIONALS.**—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) **USE OF QUALIFIED, INDEPENDENT PERSONNEL.—**

(A) **IN GENERAL.**—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) **PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.**—Such a program shall not, with respect to utilization review activities, permit or provide compensation or any-

thing of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) **PROHIBITION OF CONFLICTS.**—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) **ACCESSIBILITY OF REVIEW.**—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) **LIMITS ON FREQUENCY.**—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary and appropriate.

**SEC. 1602. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.****(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—**

(1) **IN GENERAL.**—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits.

**(2) ACCESS TO INFORMATION.—**

(A) **TIMELY PROVISION OF NECESSARY INFORMATION.**—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of subsection (b)(1), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) **LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.**—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) **ORAL REQUESTS.**—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, bene-

fiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claim for such benefits without regard to whether and when a written confirmation of such request is made.

**(b) TIMELINE FOR MAKING DETERMINATIONS.—****(1) PRIOR AUTHORIZATION DETERMINATION.—**

(A) **IN GENERAL.**—A group health plan, or health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

(B) **EXPEDITED DETERMINATION.**—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request is received by the plan or issuer under this subparagraph.

**(C) ONGOING CARE.—****(i) CONCURRENT REVIEW.—**

(I) **IN GENERAL.**—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible.

(II) **CONTENTS OF NOTICE.**—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) **RULE OF CONSTRUCTION.**—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) **RETROSPECTIVE DETERMINATION.**—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as

possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination); and

(2) the procedures for obtaining additional information concerning the determination.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term “authorized representative” means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual’s consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term “claim for benefits” means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term “denial” means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term “treating health care professional” means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

#### Subpart B—Access to Care

### SEC. 1611. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care profes-

sional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

### SEC. 1612. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization, the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w-

22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term “emergency ambulance services” means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

### SEC. 1613. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan’s or issuer’s participants, beneficiaries, or enrollees; or

(C) to override any State licensure or scope-of-practice law.

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a non-participating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(C) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialist care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(d) SPECIALIST DEFINED.—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

#### SEC. 1614. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

#### SEC. 1615. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b)

may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

#### SEC. 1616. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in subsection (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage, the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved, or arrange to have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the right to elect continued transitional care from the provider under this section;

(B) provide the patient with an opportunity to notify the plan or issuer of the patient’s need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with

respect to the course of treatment by such provider with the provider’s consent during a transitional period (as provided for under subsection (b)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term “continuing care patient” means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient’s life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in

an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term “contract” includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term “health care provider” or “provider” means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term “serious and complex condition” means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section (b)(2)(B)).

(4) TERMINATED.—The term “terminated” includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

#### Subpart C—Protecting the Doctor-Patient Relationship

#### SEC. 1621. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group

health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

#### Subpart D—Definitions

#### SEC. 1631. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this part in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term “Secretary” means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term “appropriate Secretary” means the Secretary of Health and Human Services in relation to carrying out this part under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this part under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this part:

(1) APPLICABLE AUTHORITY.—The term “applicable authority” means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term “enrollee” means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term “health care professional” means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term “health care provider” includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term “network” means, with respect to a group health plan or health

insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term “non-participating” means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term “participating” means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PRIOR AUTHORIZATION.—The term “prior authorization” means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(10) TERMS AND CONDITIONS.—The term “terms and conditions” includes, with respect to a group health plan or health insurance coverage, requirements imposed under this part with respect to the plan or coverage.

#### SEC. 1632. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this part.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this subtitle (except in the case of other substantially compliant requirements), in applying the requirements of this part under section 2720 and 2754 (as applicable) of the Public Health Service Act (as added by part II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term “patient protection requirement” means a requirement under this part, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this part.

(B) SUBSTANTIALLY COMPLIANT.—The terms “substantially compliant”, “substantially complies”, or “substantial compliance” with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(C) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State’s interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this subtitle become effective, as provided for in section 1652, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this part.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term “State” includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

**SEC. 1633. REGULATIONS.**

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this part. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this part.

**SEC. 1634. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.**

The requirements of this part with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy, certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

**PART II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT**

**SEC. 1641. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.**

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 1001, is further amended by adding at the end the following new section:

**“SEC. 2720. PATIENT PROTECTION STANDARDS.**

“Each group health plan shall comply with patient protection requirements under part I

of subtitle H of title I of the Patient Protection and Affordable Care Act, and each health insurance issuer shall comply with patient protection requirements under such part with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.”.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg-21(b)(2)(A)) is amended by inserting “(other than section 2720)” after “requirements of such subparts”.

**SEC. 1642. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.**

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2753 the following new section:

**“SEC. 2754. PATIENT PROTECTION STANDARDS.**

“Each health insurance issuer shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.”.

**SEC. 1643. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

**“SEC. 2795. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

“(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary’s authority under this title to enforce the requirements applicable under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

“(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.”.

**PART III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

**SEC. 1651. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 1562, is further amended by adding at the end the following new section:

**“SEC. 716. PATIENT PROTECTION STANDARDS.**

“(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

“(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

“(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting

the following requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

“(A) Section 1611 (relating to choice of health care professional).

“(B) Section 1612 (relating to access to emergency care).

“(C) Section 1613 (relating to timely access to specialists).

“(D) Section 1614 (relating to access to pediatric care).

“(E) Section 1615 (relating to patient access to obstetrical and gynecological care).

“(F) Section 1616 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

“(2) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 1621 of the Patient Protection and Affordable Care Act (relating to prohibition of interference with certain medical communications), the group health plan shall not be liable for such violation unless the plan caused such violation.

“(3) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

“(4) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section or other provision in subtitle H of title I of the Patient Protection and Affordable Care Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 1632(c) of such Act) with the requirement in such section or other provisions.

“(c) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.”

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting “(a)” after “SEC. 503.” and by adding at the end the following new subsection:

“(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part I of subtitle H of title I of the Patient Protection and Affordable Care Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.”

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 716”.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 715 the following new item:

“Sec. 716. Patient protection standards”.

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this title, the provisions of this section (and the amendments made by this section) shall not apply until

the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this section (or amendments) shall not be treated as a termination of such collective bargaining agreement.

**SEC. 1652. EFFECTIVE DATE.**

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

**SA 3066.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1907, after line 25, add the following:

“(P) An entity that is owned or operated by a unit of local government which provides mental health or health care services and is located in a county in which the rate of uninsurance is above the national rate of uninsurance for the under-65 population, based on the best available estimate of the rate of uninsurance published by the Bureau of the Census.”

**SA 3067.** Mr. PRYOR (for himself, Mrs. BOXER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ FEDERAL TRADE COMMISSION OVERSIGHT OVER HEALTH INSURANCE ISSUERS.**

Section 6 of the Federal Trade Commission Act (15 U.S.C. 46) is amended in the undesignated matter following subsection (1), by striking “Nothing” and all that follows through “was made,” and inserting the following:

“Notwithstanding the Act of March 9, 1945 (15 U.S.C. 1011 et seq.) and the definition of corporation in section 4, the Commission may use the authority described in this section to conduct studies, prepare reports, and disclose information relating to insurance, without regard to whether the subject of the study, report, or the information is for-profit or not-for-profit.

“Subject to the Act of March 9, 1945 (15 U.S.C. 1011 et seq.) and notwithstanding the definition of corporation in section 4, the provisions of this Act shall apply to an insurer without regard to whether such insurer is for-profit or not-for-profit. For purposes of this paragraph, an employer or membership organization not organized for its own profit or that of its members that provides health care or medical malpractice benefits only to

its employees or members shall not be deemed to be a health insurer or a medical malpractice insurer, provided that this exclusion shall not apply to a separate entity that issues insurance or to an organization whose sole or primary membership benefit is insurance.”

**SA 3068.** Mr. KYL (for himself, Mr. ROBERTS, Mr. VITTER, Mr. GRASSLEY, Mr. CRAPO, Mr. COBURN, Mr. BARRASSO, and Mr. JOHANNIS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH; ACCOUNTING FOR PERSONALIZED MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.**

(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal department, office, or representative—

(1) shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f))), including under plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code), or under private health insurance; and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

(c) PATIENT CENTERED OUTCOMES RESEARCH INSTITUTE BOARD.—Notwithstanding section 1181(f)(1)(A) and (B) of the Social Security Act (as added by section 6301(a)), no Federal officer or employee (including Federally elected officials and members of Congress) shall serve on the Board of Governors of the Patient Centered Outcomes Research Institute.

**SA 3069.** Mr. KOHL submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**TITLE —COMBATING ELDER ABUSE AND SILVER ALERTS**

**SEC. 11. SHORT TITLE.**

This title may be cited as the “Combating Elder Abuse and National Silver Alert Act of 2009”.

**Subtitle A—Elder Abuse Victims Act of 2009**

**SEC. 21. SHORT TITLE.**

This subtitle may be cited as the “Elder Abuse Victims Act of 2009”.

**PART I—ELDER ABUSE VICTIMS**

**SEC. 31. ANALYSIS, REPORT, AND RECOMMENDATIONS RELATED TO ELDER JUSTICE PROGRAMS.**

(a) **IN GENERAL.**—Subject to the availability of appropriations to carry out this section, the Attorney General, in consultation with the Secretary of Health and Human Services, shall carry out the following:

(1) **STUDY.**—Conduct a study of laws and practices relating to elder abuse, neglect, and exploitation, which shall include—

(A) a comprehensive description of State laws and practices relating to elder abuse, neglect, and exploitation;

(B) a comprehensive analysis of the effectiveness of such State laws and practices; and

(C) an examination of State laws and practices relating to specific elder abuse, neglect, and exploitation issues, including—

(i) the definition of—  
(I) “elder”;  
(II) “abuse”;  
(III) “neglect”;  
(IV) “exploitation”; and  
(V) such related terms the Attorney General determines to be appropriate;

(ii) mandatory reporting laws, with respect to—

(I) who is a mandated reporter;  
(II) to whom must they report and within what time frame; and

(III) any consequences for not reporting;  
(iii) evidentiary, procedural, sentencing, choice of remedies, and data retention issues relating to pursuing cases relating to elder abuse, neglect, and exploitation;

(iv) laws requiring reporting of all nursing home deaths to the county coroner or to some other individual or entity;

(v) fiduciary laws, including guardianship and power of attorney laws;

(vi) laws that permit or encourage banks and bank employees to prevent and report suspected elder abuse, neglect, and exploitation;

(vii) laws relating to fraud and related activities in connection with mail, telemarketing, or the Internet;

(viii) laws that may impede research on elder abuse, neglect, and exploitation;

(ix) practices relating to the enforcement of laws relating to elder abuse, neglect, and exploitation; and

(x) practices relating to other aspects of elder justice.

(2) **DEVELOPMENT OF PLAN.**—Develop objectives, priorities, policies, and a long-term plan for elder justice programs and activities relating to—

(A) prevention and detection of elder abuse, neglect, and exploitation;

(B) intervention and treatment for victims of elder abuse, neglect, and exploitation;

(C) training, evaluation, and research related to elder justice programs and activities; and

(D) improvement of the elder justice system in the United States.

(3) **REPORT.**—Not later than 2 years after the date of enactment of this Act, submit to the chairman and ranking member of the Special Committee on Aging of the Senate, and the Speaker and minority leader of the

House of Representatives, and the Secretary of Health and Human Services, and make available to the States, a report that contains—

(A) the findings of the study conducted under paragraph (1);

(B) a description of the objectives, priorities, policies, and a long-term plan developed under paragraph (2); and

(C) a list, description, and analysis of the best practices used by States to develop, implement, maintain, and improve elder justice systems, based on such findings.

(b) **GAO RECOMMENDATIONS.**—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall review existing Federal programs and initiatives in the Federal criminal justice system relevant to elder justice and shall submit to Congress—

(1) a report on such programs and initiatives; and

(2) any recommendations the Comptroller General determines are appropriate to improve elder justice in the United States.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. 32. VICTIM ADVOCACY GRANTS.**

(a) **GRANTS AUTHORIZED.**—The Attorney General, after consultation with the Secretary of Health and Human Services, may award grants to eligible entities to study the special needs of victims of elder abuse, neglect, and exploitation.

(b) **AUTHORIZED ACTIVITIES.**—Funds awarded pursuant to subsection (a) shall be used for pilot programs that—

(1) develop programs for and provide training to health care, social, and protective services providers, law enforcement, fiduciaries (including guardians), judges and court personnel, and victim advocates; and

(2) examine special approaches designed to meet the needs of victims of elder abuse, neglect, and exploitation.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$3,000,000 for each of the fiscal years 2010 through 2016.

**SEC. 33. SUPPORTING LOCAL PROSECUTORS AND COURTS IN ELDER JUSTICE MATTERS.**

(a) **GRANTS AUTHORIZED.**—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, shall award grants to eligible entities to provide training, technical assistance, policy development, multidisciplinary coordination, and other types of support to local prosecutors and courts handling elder justice-related cases, including—

(1) funding specially designated elder justice positions or units in local prosecutors’ offices and local courts; and

(2) funding the creation of a Center for the Prosecution of Elder Abuse, Neglect, and Exploitation to advise and support local prosecutors and courts nationwide in the pursuit of cases involving elder abuse, neglect, and exploitation.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. 34. SUPPORTING STATE PROSECUTORS AND COURTS IN ELDER JUSTICE MATTERS.**

(a) **IN GENERAL.**—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, shall award grants to eligible entities to provide training, technical assistance, multidisciplinary coordination, policy devel-

opment, and other types of support to State prosecutors and courts, employees of State Attorneys General, and Medicaid Fraud Control Units handling elder justice-related matters.

(b) **CREATING SPECIALIZED POSITIONS.**—Grants under this section may be made for—

(1) the establishment of specially designated elder justice positions or units in State prosecutors’ offices and State courts; and

(2) the creation of a position to coordinate elder justice-related cases, training, technical assistance, and policy development for State prosecutors and courts.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. 35. SUPPORTING LAW ENFORCEMENT IN ELDER JUSTICE MATTERS.**

(a) **IN GENERAL.**—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, the Postmaster General, and the Chief Postal Inspector for the United States Postal Inspection Service, shall award grants to eligible entities to provide training, technical assistance, multidisciplinary coordination, policy development, and other types of support to police, sheriffs, detectives, public safety officers, corrections personnel, and other first responders who handle elder justice-related matters, to fund specially designated elder justice positions or units designed to support first responders in elder justice matters.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$8,000,000 for each of the fiscal years 2010 through 2016.

**SEC. 36. EVALUATIONS.**

(a) **GRANTS UNDER THIS PART.**—

(1) **IN GENERAL.**—In carrying out the grant programs under this part, the Attorney General shall—

(A) require each recipient of a grant to use a portion of the funds made available through the grant to conduct a validated evaluation of the effectiveness of the activities carried out through the grant by such recipient; or

(B) as the Attorney General considers appropriate, use a portion of the funds available under this part for a grant program under this part to provide assistance to an eligible entity to conduct a validated evaluation of the effectiveness of the activities carried out through such grant program by each of the grant recipients.

(2) **APPLICATIONS.**—

(A) **SUBMISSION.**—To be eligible to receive a grant under this part, an entity shall submit an application to the Attorney General at such time, in such manner, and containing such information as the Attorney General may require, which shall include—

(i) a proposal for the evaluation required in accordance with paragraph (1)(A); and

(ii) the amount of assistance under paragraph (1)(B) the entity is requesting, if any.

(B) **REVIEW AND ASSISTANCE.**—

(i) **IN GENERAL.**—An employee of the Department of Justice, after consultation with an employee of the Department of Health and Human Services with expertise in evaluation methodology, shall review each application described in subparagraph (A) and determine whether the methodology described in the proposal under subparagraph (A)(i) is adequate to gather meaningful information.

(ii) **DENIAL.**—If the reviewing employee determines the methodology described in such proposal is inadequate, the reviewing employee shall recommend that the Attorney General deny the application for the grant,

or make recommendations for how the application should be amended.

(iii) NOTICE TO APPLICANT.—If the Attorney General denies the application on the basis of such proposal, the Attorney General shall inform the applicant of the reasons the application was denied, and offer assistance to the applicant in modifying the proposal.

(b) OTHER GRANTS.—Subject to the availability of appropriations under this section, the Attorney General shall award grants to appropriate entities to conduct validated evaluations of grant activities that are funded by Federal funds not provided under this part, or other funds, to reduce elder abuse, neglect, and exploitation.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$7,000,000 for each of the fiscal years 2010 through 2016.

#### SEC. 37. DEFINITIONS.

In this part:

(1) ELDER.—The term “elder” means an individual age 60 or older.

(2) ELDER JUSTICE.—The term “elder justice” means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

(3) ELIGIBLE ENTITIES.—The term “eligible entity” means a State or local government agency, Indian tribe or tribal organization, or any other public or nonprofit private entity that is engaged in and has expertise in issues relating to elder justice or a field necessary to promote elder justice efforts.

#### PART II—ELDER SERVE VICTIM GRANT PROGRAMS

#### SEC. 41. ESTABLISHMENT OF ELDER SERVE VICTIM GRANT PROGRAMS.

(a) ESTABLISHMENT.—The Attorney General, acting through the Director of the Office of Victims of Crime of the Department of Justice (in this section referred to as the “Director”), shall, subject to appropriations, carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the “Program”) to provide grants to eligible entities to establish programs to facilitate and coordinate programs described in subsection (e) for victims of elder abuse.

(b) ELIGIBILITY REQUIREMENTS FOR GRANTEES.—To be eligible to receive a grant under the Program, an entity must meet the following criteria:

(1) ELIGIBLE CRIME VICTIM ASSISTANCE PROGRAM.—The entity is a crime victim assistance program receiving a grant under the Victims of Crime Act of 1984 (42 U.S.C. 1401 et seq.) for the period described in subsection (c)(2) with respect to the grant sought under this section.

(2) COORDINATION WITH LOCAL COMMUNITY BASED AGENCIES AND SERVICES.—The entity shall demonstrate to the satisfaction of the Director that such entity has a record of community coordination or established contacts with other county and local services that serve elderly individuals.

(3) ABILITY TO CREATE ECRT ON TIMELY BASIS.—The entity shall demonstrate to the satisfaction of the Director the ability of the entity to create, not later than 6 months after receiving such grant, an Emergency Crisis Response Team program described in subsection (e)(1) and the programs described in subsection (e)(2).

For purposes of meeting the criteria described in paragraph (2), for each year an en-

tity receives a grant under this section the entity shall provide a record of community coordination or established contacts described in such paragraph through memoranda of understanding, contracts, subcontracts, and other such documentation.

(c) ADMINISTRATIVE PROVISIONS.—

(1) CONSULTATION.—Each program established pursuant to this section shall be developed and carried out in consultation with the following entities, as appropriate:

(A) Relevant Federal, State, and local public and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elderly individuals.

(B) Local law enforcement including police, sheriffs, detectives, public safety officers, corrections personnel, prosecutors, medical examiners, investigators, and coroners.

(C) Long-term care and nursing facilities.

(2) GRANT PERIOD.—Grants under the Program shall be issued for a three-year period.

(3) LOCATIONS.—The Program shall be carried out in six geographically and demographically diverse locations, taking into account—

(A) the number of elderly individuals residing in or near an area; and

(B) the difficulty of access to immediate short-term housing and health services for victims of elder abuse.

(d) PERSONNEL.—In providing care and services, each program established pursuant to this section may employ a staff to assist in creating an Emergency Crisis Response Teams under subsection (e)(1).

(e) USE OF GRANTS.—

(1) EMERGENCY CRISIS RESPONSE TEAM.—Each entity that receives a grant under this section shall use such grant to establish an Emergency Crisis Response Team program by not later than the date that is six months after the entity receives the grant. Under such program the following shall apply:

(A) Such program shall include immediate, short-term emergency services, including shelter, care services, food, clothing, transportation to medical or legal appointment as appropriate, and any other life services deemed necessary by the entity for victims of elder abuse.

(B) Such program shall provide services to victims of elder abuse, including those who have been referred to the program through the adult protective services agency of the local law enforcement or any other relevant law enforcement or referral agency.

(C) A victim of elder abuse may not receive short-term housing under the program for more than 30 consecutive days.

(D) The entity that established the program shall enter into arrangements with the relevant local law enforcement agencies so that the program receives quarterly reports from such agencies on elder abuse.

(2) ADDITIONAL SERVICES REQUIRED TO BE PROVIDED.—Not later than one year after the date an entity receives a grant under this section, such entity shall have established the following programs (and community collaborations to support such programs):

(A) COUNSELING.—A program that provides counseling and assistance for victims of elder abuse accessing health care, educational, pension, or other benefits for which seniors may be eligible under Federal or applicable State law.

(B) MENTAL HEALTH SCREENING.—A program that provides mental health screenings for victims of elder abuse to identify and seek assistance for potential mental health disorders such as depression or substance abuse.

(C) EMERGENCY LEGAL ADVOCACY.—A program that provides legal advocacy for victims of elder abuse and, as appropriate, their families.

(D) JOB PLACEMENT ASSISTANCE.—A program that provides job placement assistance and information on employment, training, or volunteer opportunities for victims of elder abuse.

(E) BEREAVEMENT COUNSELING.—A program that provides bereavement counseling for families of victims of elder abuse.

(F) OTHER SERVICES.—A program that provides such other care, services, and assistance as the entity considers appropriate for purposes of the program.

(f) TECHNICAL ASSISTANCE.—The Director shall enter into contracts with private entities with experience in elder abuse coordination or victim services to provide such technical assistance to grantees under this section as the entity determines appropriate.

(g) REPORTS TO CONGRESS.—Not later than 12 months after the commencement of the Program, and annually thereafter, the entity shall submit a report to the Chairman and Ranking Member of the Committee on the Judiciary of the House of Representatives, and the Chairman and Ranking Member of the Special Committee on Aging of the Senate. Each report shall include the following:

(1) A description and assessment of the implementation of the Program.

(2) An assessment of the effectiveness of the Program in providing care and services to seniors, including a comparative assessment of effectiveness for each of the locations designated under subsection (c)(3) for the Program.

(3) An assessment of the effectiveness of the coordination for programs described in subsection (e) in contributing toward the effectiveness of the Program.

(4) Such recommendations as the entity considers appropriate for modifications of the Program in order to better provide care and services to seniors.

(h) DEFINITIONS.—For purposes of this section:

(1) ELDER ABUSE.—The term “elder abuse” means any type of violence or abuse, whether mental or physical, inflicted upon an elderly individual, and any type of criminal financial exploitation of an elderly individual.

(2) ELDERLY INDIVIDUAL.—The term “elderly individual” means an individual who is age 60 or older.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the Department of Justice to carry out this section \$3,000,000 for each of the fiscal years 2010 through 2012.

#### Subtitle B—National Silver Alert

#### SEC. 51. SHORT TITLE.

This subtitle may be cited as the “National Silver Alert Act”.

#### SEC. 52. DEFINITIONS.

For purposes of this subtitle:

(1) STATE.—The term “State” means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(2) MISSING SENIOR.—The term “missing senior” refers to any individual who—

(A) is reported to, or identified by, a law enforcement agency as a missing person; and

(B) meets the requirements to be designated as a missing senior, as determined by the State in which the individual is reported or identified as a missing person.

#### SEC. 53. SILVER ALERT COMMUNICATIONS NETWORK.

The Attorney General shall, subject to the availability of appropriations under section 57, establish a national Silver Alert communications network within the Department of Justice to provide assistance to regional and local search efforts for missing seniors through the initiation, facilitation, and promotion of local elements of the network

(known as Silver Alert plans) in coordination with States, units of local government, law enforcement agencies, and other concerned entities with expertise in providing services to seniors.

**SEC. 54. SILVER ALERT COORDINATOR.**

(a) NATIONAL COORDINATOR WITHIN DEPARTMENT OF JUSTICE.—The Attorney General shall designate an individual of the Department of Justice to act as the national coordinator of the Silver Alert communications network. The individual so designated shall be known as the Silver Alert Coordinator of the Department of Justice (referred to in this subtitle as the “Coordinator”).

(b) DUTIES OF THE COORDINATOR.—In acting as the national coordinator of the Silver Alert communications network, the Coordinator shall—

(1) work with States to encourage the development of additional Silver Alert plans in the network;

(2) establish voluntary guidelines for States to use in developing Silver Alert plans that will promote compatible and integrated Silver Alert plans throughout the United States, including—

(A) a list of the resources necessary to establish a Silver Alert plan;

(B) criteria for evaluating whether a situation warrants issuing a Silver Alert, taking into consideration the need for the use of such Alerts to be limited in scope because the effectiveness of the Silver Alert communications network may be affected by overuse, including criteria to determine—

(i) whether the mental capacity of a senior who is missing, and the circumstances of his or her disappearance, warrant the issuance a Silver Alert; and

(ii) whether the individual who reports that a senior is missing is an appropriate and credible source on which to base the issuance of a Silver Alert;

(C) a description of the appropriate uses of the Silver Alert name to readily identify the nature of search efforts for missing seniors; and

(D) recommendations on how to protect the privacy, dignity, independence, and autonomy of any missing senior who may be the subject of a Silver Alert;

(3) develop proposed protocols for efforts to recover missing seniors and to reduce the number of seniors who are reported missing, including protocols for procedures that are needed from the time of initial notification of a law enforcement agency that the senior is missing through the time of the return of the senior to family, guardian, or domicile, as appropriate, including—

(A) public safety communications protocol;

(B) case management protocol;

(C) command center operations;

(D) reunification protocol; and

(E) incident review, evaluation, debriefing, and public information procedures;

(4) work with States to ensure appropriate regional coordination of various elements of the network;

(5) establish an advisory group to assist States, units of local government, law enforcement agencies, and other entities involved in the Silver Alert communications network with initiating, facilitating, and promoting Silver Alert plans, which shall include—

(A) to the maximum extent practicable, representation from the various geographic regions of the United States; and

(B) members who are—

(i) representatives of senior citizen advocacy groups, law enforcement agencies, and public safety communications;

(ii) broadcasters, first responders, dispatchers, and radio station personnel; and

(iii) representatives of any other individuals or organizations that the Coordinator

determines are necessary to the success of the Silver Alert communications network; and

(6) act as the nationwide point of contact for—

(A) the development of the network; and

(B) regional coordination of alerts for missing seniors through the network.

(c) COORDINATION.—

(1) COORDINATION WITH OTHER AGENCIES.—The Coordinator shall coordinate and consult with the Secretary of Transportation, the Federal Communications Commission, the Assistant Secretary for Aging of the Department of Health and Human Services, the head of the Missing Alzheimer’s Disease Patient Alert Program, and other appropriate offices of the Department of Justice in carrying out activities under this subtitle.

(2) STATE AND LOCAL COORDINATION.—The Coordinator shall consult with local broadcasters and State and local law enforcement agencies in establishing minimum standards under section 55 and in carrying out other activities under this subtitle, as appropriate.

(d) ANNUAL REPORTS.—Not later than one year after the date of enactment of this Act, and annually thereafter, the Coordinator shall submit to Congress a report on the activities of the Coordinator and the effectiveness and status of the Silver Alert plans of each State that has established or is in the process of establishing such a plan. Each such report shall include—

(1) a list of States that have established Silver Alert plans;

(2) a list of States that are in the process of establishing Silver Alert plans;

(3) for each State that has established such a plan, to the extent the data is available—

(A) the number of Silver Alerts issued;

(B) the number of individuals located successfully;

(C) the average period of time between the issuance of a Silver Alert and the location of the individual for whom such Alert was issued;

(D) the State agency or authority issuing Silver Alerts, and the process by which Silver Alerts are disseminated;

(E) the cost of establishing and operating such a plan;

(F) the criteria used by the State to determine whether to issue a Silver Alert; and

(G) the extent to which missing individuals for whom Silver Alerts were issued crossed State lines;

(4) actions States have taken to protect the privacy and dignity of the individuals for whom Silver Alerts are issued;

(5) ways that States have facilitated and improved communication about missing individuals between families, caregivers, law enforcement officials, and other authorities; and

(6) any other information the Coordinator determines to be appropriate.

**SEC. 55. MINIMUM STANDARDS FOR ISSUANCE AND DISSEMINATION OF ALERTS THROUGH SILVER ALERT COMMUNICATIONS NETWORK.**

(a) ESTABLISHMENT OF MINIMUM STANDARDS.—Subject to subsection (b), the Coordinator shall establish minimum standards for—

(1) the issuance of alerts through the Silver Alert communications network; and

(2) the extent of the dissemination of alerts issued through the network.

(b) LIMITATIONS.—

(1) VOLUNTARY PARTICIPATION.—The minimum standards established under subsection (a) of this section, and any other guidelines and programs established under section 54, shall be adoptable on a voluntary basis only.

(2) DISSEMINATION OF INFORMATION.—The minimum standards shall, to the maximum

extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that appropriate information relating to the special needs of a missing senior (including health care needs) are disseminated to the appropriate law enforcement, public health, and other public officials.

(3) GEOGRAPHIC AREAS.—The minimum standards shall, to the maximum extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that the dissemination of an alert through the Silver Alert communications network be limited to the geographic areas which the missing senior could reasonably reach, considering the missing senior’s circumstances and physical and mental condition, the modes of transportation available to the missing senior, and the circumstances of the disappearance.

(4) AGE REQUIREMENTS.—The minimum standards shall not include any specific age requirement for an individual to be classified as a missing senior for purposes of the Silver Alert communication network. Age requirements for determinations of whether an individual is a missing senior shall be determined by each State, and may vary from State to State.

(5) PRIVACY AND CIVIL LIBERTIES PROTECTIONS.—The minimum standards shall—

(A) ensure that alerts issued through the Silver Alert communications network comply with all applicable Federal, State, and local privacy laws and regulations; and

(B) include standards that specifically provide for the protection of the civil liberties and sensitive medical information of missing seniors.

(6) STATE AND LOCAL VOLUNTARY COORDINATION.—In carrying out the activities under subsection (a), the Coordinator may not interfere with the current system of voluntary coordination between local broadcasters and State and local law enforcement agencies for purposes of the Silver Alert communications network.

**SEC. 56. TRAINING AND OTHER RESOURCES.**

(a) TRAINING AND EDUCATIONAL PROGRAMS.—The Coordinator shall make available to States, units of local government, law enforcement agencies, and other concerned entities that are involved in initiating, facilitating, or promoting Silver Alert plans, including broadcasters, first responders, dispatchers, public safety communications personnel, and radio station personnel—

(1) training and educational programs related to the Silver Alert communication network and the capabilities, limitations, and anticipated behaviors of missing seniors, which shall be updated regularly to encourage the use of new tools, technologies, and resources in Silver Alert plans; and

(2) informational materials, including brochures, videos, posters, and websites to support and supplement such training and educational programs.

(b) COORDINATION.—The Coordinator shall coordinate—

(1) with the Assistant Secretary for Aging of the Department of Health and Human Services in developing the training and educational programs and materials under subsection (a); and

(2) with the head of the Missing Alzheimer’s Disease Patient Alert Program within the Department of Justice, to determine if any existing material with respect to training programs or educational materials developed or used as subtitle of such Patient Alert Program are appropriate and may be used for the programs under subsection (a).

**SEC. 57. AUTHORIZATION OF APPROPRIATIONS FOR THE SILVER ALERT COMMUNICATIONS NETWORK.**

There are authorized to be appropriated to the Department of Justice such sums as may be necessary to carry out the Silver Alert communications network as authorized under this subtitle.

**SEC. 58. GRANT PROGRAM FOR SUPPORT OF SILVER ALERT PLANS.**

(a) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall carry out a program to provide grants to States for the development and enhancement of programs and activities for the support of Silver Alert plans and the Silver Alert communications network.

(b) ACTIVITIES.—Activities funded by grants under the program under subsection (a) may include—

(1) the development and implementation of education and training programs, and associated materials, relating to Silver Alert plans;

(2) the development and implementation of law enforcement programs, and associated equipment, relating to Silver Alert plans;

(3) the development and implementation of new technologies to improve Silver Alert communications; and

(4) such other activities as the Attorney General considers appropriate for supporting the Silver Alert communications network.

(c) FEDERAL SHARE.—The Federal share of the cost of any activities funded by a grant under the program under subsection (a) may not exceed 50 percent.

(d) DISTRIBUTION OF GRANTS ON GEOGRAPHIC BASIS.—The Attorney General shall, to the maximum extent practicable, ensure the distribution of grants under the program under subsection (a) on an equitable basis throughout the various regions of the United States.

(e) ADMINISTRATION.—The Attorney General shall prescribe requirements, including application requirements, for grants under the program under subsection (a).

**(f) AUTHORIZATION OF APPROPRIATIONS.—**

(1) There is authorized to be appropriated to the Department of Justice \$5,000,000 for each of the fiscal years 2010 through 2014 to carry out this section and, in addition, \$5,000,000 for each of the fiscal years 2010 through 2014 to carry out subsection (b)(3).

(2) Amounts appropriated pursuant to the authorization of appropriations in paragraph (1) shall remain available until expended.

**SEC. 59. SAMMY KIRK VOLUNTARY ELECTRONIC MONITORING PROGRAM.**

(a) PROGRAM AUTHORIZED.—The Attorney General, after consultation with the Secretary of Health and Human Services, is authorized to award grants to States and units of local government to carry out programs to provide voluntary electronic monitoring services to elderly individuals to assist in the location of such individuals if such individuals are reported as missing.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$2,000,000 for each of the fiscal years 2010 through 2014.

(c) DESIGNATION.—The grant program authorized under this section shall be referred to as the “Sammy Kirk Voluntary Electronic Monitoring Program”.

**Subtitle C—Kristen’s Act Reauthorization**

**SEC. 61. SHORT TITLE.**

This subtitle may be cited as “Kristen’s Act Reauthorization of 2009”.

**SEC. 62. FINDINGS.**

Congress finds the following:

(1) Every year thousands of adults become missing due to advanced age, diminished mental capacity, or foul play. Often there is no information regarding the whereabouts of

these adults and many of them are never reunited with their families.

(2) Missing adults are at great risk of both physical harm and sexual exploitation.

(3) In most cases, families and local law enforcement officials have neither the resources nor the expertise to undertake appropriate search efforts for a missing adult.

(4) The search for a missing adult requires cooperation and coordination among Federal, State, and local law enforcement agencies and assistance from distant communities where the adult may be located.

(5) Federal assistance is urgently needed to help with coordination among such agencies.

**SEC. 63. GRANTS FOR THE ASSISTANCE OF ORGANIZATIONS TO FIND MISSING ADULTS.**

**(a) GRANTS.—**

(1) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall make competitive grants to public agencies or nonprofit private organizations, or combinations thereof, to—

(A) maintain a national resource center and information clearinghouse for missing and unidentified adults;

(B) maintain a national, interconnected database for the purpose of tracking missing adults who are determined by law enforcement to be endangered due to age, diminished mental capacity, or the circumstances of disappearance, when foul play is suspected or circumstances are unknown;

(C) coordinate public and private programs that locate or recover missing adults or reunite missing adults with their families;

(D) provide assistance and training to law enforcement agencies, State and local governments, elements of the criminal justice system, nonprofit organizations, and individuals in the prevention, investigation, prosecution, and treatment of cases involving missing adults;

(E) provide assistance to families in locating and recovering missing adults; and

(F) assist in public notification and victim advocacy related to missing adults.

(2) APPLICATIONS.—The Attorney General shall periodically solicit applications for grants under this section by publishing a request for applications in the Federal Register and by posting such a request on the website of the Department of Justice.

(b) OTHER DUTIES.—The Attorney General shall—

(1) coordinate programs relating to missing adults that are funded by the Federal Government; and

(2) encourage coordination between State and local law enforcement and public agencies and nonprofit private organizations receiving a grant pursuant to subsection (a).

**SEC. 64. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to carry out this subtitle \$4,000,000 for each of fiscal years 2010 through 2020.

**SA 3070.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, between lines 9 and 10, insert the following:

**SEC. 2504. EXCEPTION TO MEDICAID COVERAGE EXCLUSION OF WEIGHT LOSS DRUGS AND INCLUSION OF WEIGHT LOSS DRUGS AS COVERED MEDICARE PART D DRUGS.**

(a) ELIMINATION OF MEDICAID EXCLUSION.—Section 1927(d)(2)(A) of the Social Security Act (42 U.S.C. 1396r-8(d)(2)(A)) is amended by inserting “, other than prescription weight loss agents approved by the Food and Drug Administration when used for obese patients or for overweight patients with a weight-related co-morbidity, such as hypertension, type 2 diabetes, or dyslipidemia” after “weight gain”.

(b) INCLUSION OF COVERAGE UNDER MEDICARE PART D.—Section 1860D-2(e)(1) of the Social Security Act (42 U.S.C. 1395w-102(e)(1)) is amended in the flush matter after and below subparagraph (B), by inserting “and prescription weight loss agents approved by the Food and Drug Administration when used for obese patients or for overweight patients with a weight-related co-morbidity such as hypertension, type 2 diabetes or dyslipidemia,” before the period.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

**SA 3071.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 861, between lines 19 and 20, insert the following:

**SEC. 3137A. TREATMENT OF CERTAIN MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) RECLASSIFICATIONS.**

(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of making payments under Section 1886(d) of the Social Security Act (42 U.S.C. 1395 ww (d)), the Secretary of Health and Human Services shall permit any hospital with Medicare Geographic Classification Review Board reclassifications that overlap for one fiscal year with the option to continue year three of the earlier reclassification while waiving year one of the subsequent reclassification. Such option shall be in addition to the option to immediately transition to year one of the subsequent reclassification with the loss of year three of the earlier reclassification.

**(b) APPLICATION.—**

(1) IN GENERAL.—Subsection (a) shall apply to discharges occurring on or after October 1, 2009.

(2) SPECIAL RULE FOR FY 2010.—In the case of any hospital whose year three Medicare Geographic Classification Review Board reclassification was lost or eliminated for fiscal 2010, the Secretary of Health and Human Services shall establish a process under which such hospital shall have 30 days from the date of the enactment of this Act to notify the Secretary of the hospital’s election to continue for fiscal 2010 the third year of their earlier Medicare Geographic Classification Review Board reclassification.

**SA 3072.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue

Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1255, line 14, after the first period insert the following:

**“SEC. 399MM-4. WORKPLACE DISEASE MANAGEMENT AND WELLNESS PUBLIC-PRIVATE PARTNERSHIP.**

“(a) IN GENERAL.—The Secretary, in coordination with the Secretary of Labor, the Secretary of the Treasury, the Secretary of Commerce, the Administrator of the Small Business Administration, employers (including small, medium, and large employers), employer organizations, worksite health promotion organizations, State and local health departments, Indian tribes and tribal organizations, and academic institutions, shall provide for the implementation of a national public-private partnership to—

“(1) promote the benefits of workplace wellness programs;

“(2) understand what types of disease prevention and workplace wellness programs are effective, considering different environments, factors, and circumstances;

“(3) understand the obstacles to the implementation of disease prevention and workplace wellness programs, issues relating to employer size and resources, and best practices for the scalable implementation of such programs;

“(4) understand what factors influence employees to participate in workplace disease prevention and wellness programs;

“(5) emphasize an integrated and coordinated approach to workplace disease management and wellness programs;

“(6) ensure informed decisions through the sharing of high quality information and best practices; and

“(7) recommend policies to encourage or stimulate the utilization of worksite disease management and wellness programs, including specific recommendations as to the types of technical and other assistance that may be necessary to fully implement section 399MM.

“(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall 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 contains—

“(1) the findings of the public-private partnership implemented under subsection (a); and

“(2) recommendations for statutory changes that may be required or useful to implement the findings described in paragraph (1) and to encourage the development of worksite disease management and wellness programs.

“(c) RECOMMENDATIONS BY CDC.—The Director of the Centers for Disease Control and Prevention shall collect information concerning workplace wellness programs and make recommendations to the Secretary on ways to improve such programs.”.

**SA 3073.** Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. . ADULT DAY HEALTH CARE SERVICES.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) EFFECTIVE DATE.—Subsection (a) shall apply with respect to services provided on or after October 1, 2008.

**SA 3074.** Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 453, between lines 5 and 6, insert the following:

**SEC. 2203. PERMITTING LOCAL PUBLIC AGENCIES TO ACT AS MEDICAID ENROLLMENT BROKERS.**

Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(b)(4)) is amended by adding at the end the following new subparagraph:

“(C)(i) Subparagraphs (A) and (B) shall not apply in the case of a local public agency that is acting as an enrollment broker under a contract or memorandum with a State Medicaid agency, provided the local public agency does not have a direct or indirect financial interest with any Medicaid managed care plan for which it provides enrollment broker services.

“(ii) In determining whether a local public agency has a direct or indirect financial interest with a Medicaid managed care plan under clause (i), the status of a local public agency as a contractor of the plan does not constitute having a direct or indirect financial interest with the plan.”.

**SA 3075.** Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

**Subtitle F—Programs Relating to Congenital Heart Disease**

**SEC. 4501. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.**

(a) SHORT TITLE.—This subtitle may be cited as the “Congenital Heart Futures Act”.

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) PUBLIC EDUCATION AND AWARENESS; NATIONAL REGISTRY; ADVISORY COMMITTEE.—

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 4303, is further amended by adding at the end the following:

**“PART V—PROGRAMS RELATING TO CONGENITAL HEART DISEASE**

**“SEC. 399NN-1. PUBLIC EDUCATION AND AWARENESS OF CONGENITAL HEART DISEASE.**

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate congenital heart disease patient organizations and professional organizations, may directly or through grants, cooperative agreements, or contracts to eligible entities conduct, support, and promote a comprehensive public education and awareness campaign to increase public and medical community awareness regarding congenital heart disease, including the need for life-long treatment of congenital heart disease survivors.

“(b) ELIGIBILITY FOR GRANTS.—To be eligible to receive a grant, cooperative agreement, or contract under this section, an entity shall be a State or private nonprofit entity and shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.”.

**“SEC. 399NN-2. NATIONAL CONGENITAL HEART DISEASE REGISTRY.**

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

“(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative surveillance system with development of a population-based registry of actual occurrences of congenital heart disease, to be known as the ‘National Congenital Heart Disease Registry’; or

“(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

“(b) PURPOSE.—The purpose of the Congenital Heart Disease Registry shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

“(c) CONTENT.—The Congenital Heart Disease Registry—

“(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

“(2) may be used to collect and store data on congenital heart disease, including data concerning—

“(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

“(B) risk factors associated with the disease;

“(C) causation of the disease;

“(D) treatment approaches; and

“(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

“(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

“(d) COORDINATION WITH FEDERAL, STATE, AND LOCAL REGISTRIES.—In establishing the National Congenital Heart Registry, the Secretary may identify, build upon, expand, and coordinate among existing data and surveillance systems, surveys, registries, and other

Federal public health infrastructure, including—

“(1) State birth defects surveillance systems;

“(2) the State birth defects tracking systems of the Centers for Disease Control and Prevention;

“(3) the Metropolitan Atlanta Congenital Defects Program; and

“(4) the National Birth Defects Prevention Network.

“(e) PUBLIC ACCESS.—The Congenital Heart Disease Registry shall be made available to the public, as appropriate, including congenital heart disease researchers.

“(f) PATIENT PRIVACY.—The Secretary shall ensure that the Congenital Heart Disease Registry is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

“(g) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

“(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

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

“(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.”

**“SEC. 399NN-3. ADVISORY COMMITTEE ON CONGENITAL HEART DISEASE.**

“(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may establish an advisory committee, to be known as the ‘Advisory Committee on Congenital Heart Disease’ (referred to in this section as the ‘Advisory Committee’).

“(b) MEMBERSHIP.—The members of the Advisory Committee may be appointed by the Secretary, acting through the Centers for Disease Control and Prevention, and shall include—

“(1) at least one representative from—

“(A) the National Institutes of Health;

“(B) the Centers for Disease Control and Prevention; and

“(C) a national patient advocacy organization with experience advocating on behalf of patients living with congenital heart disease;

“(2) at least one epidemiologist who has experience working with data registries;

“(3) clinicians, including—

“(A) at least one with experience diagnosing or treating congenital heart disease; and

“(B) at least one with experience using medical data registries; and

“(4) at least one publicly or privately funded researcher with experience researching congenital heart disease.

“(c) DUTIES.—The Advisory Committee may review information and make recommendations to the Secretary concerning—

“(1) the development and maintenance of the National Congenital Heart Disease Registry established under section 399NN-2;

“(2) the type of data to be collected and stored in the National Congenital Heart Disease Registry;

“(3) the manner in which such data is to be collected;

“(4) the use and availability of such data, including guidelines for such use; and

“(5) other matters, as the Secretary determines to be appropriate.

“(d) REPORT.—Not later than 180 days after the date on which the Advisory Committee is established and annually thereafter, the Advisory Committee shall submit a report to

the Secretary concerning the information described in subsection (c), including recommendations with respect to the results of the Advisory Committee’s review of such information.”

(2) CONGENITAL HEART DISEASE RESEARCH.—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by adding at the end the following: **“SEC. 425. CONGENITAL HEART DISEASE.**

“(a) IN GENERAL.—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

“(1) causation of congenital heart disease, including genetic causes;

“(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

“(3) diagnosis, treatment, and prevention;

“(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

“(5) identifying barriers to life-long care for individuals with congenital heart disease.

“(b) COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

“(c) MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.—In carrying out the activities described in this section, the Director of the Institute shall consider the application of such research and other activities to minority and medically underserved communities.”

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2010 through 2014.

**SA 3076.** Mr. DURBIN (for himself and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 4107 and insert the following:

**SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID.**

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking “and” before “(C)”; and

(B) by inserting before the semicolon at the end the following new subparagraph: “; and (D) counseling and pharmacotherapy for cessation of tobacco use (as defined in subsection (bb))”; and

(2) by adding at the end the following:

“(bb)(1) For purposes of this title, the term ‘counseling and pharmacotherapy for cessation of tobacco use’ means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco

cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use that is furnished—

“(A) by or under the supervision of a physician; or

“(B) by any other health care professional who—

“(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

“(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

“(2) Subject to paragraph (3), such term is limited to—

“(A) services recommended with respect to individuals in ‘Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline’, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

“(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use.

“(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.”

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r-8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: “, except when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation”.

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396e) is amended in each of subsections (a)(2)(D) and (b)(2)(D) by inserting “and counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accordance with the Guideline referred to in section 1905(bb)(2)(A)” after “section 1905(a)(4)(C)”;.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B) of such Act (42 U.S.C. 1396o-1(b)(3)(B)) is amended by adding at the end the following:

“(xi) Counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accordance with the Guideline referred to in section 1905(bb)(2)(A).”

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

**SA 3077.** Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, add the following:

**SEC. 3115. MEDICARE PASS-THROUGH PAYMENTS FOR CRNA SERVICES.**

(a) TREATMENT OF CRITICAL ACCESS HOSPITALS AS RURAL IN DETERMINING ELIGIBILITY FOR CRNA PASS-THROUGH PAYMENTS.—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395k note), as added by section 608(c)(2) of the Family Support Act of 1988 and amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, is amended by adding at the end the following:

“(3) Any facility that qualifies as a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act) shall be treated as being located in a rural area for purposes of paragraph (1) regardless of any geographic reclassification of the facility, including such a reclassification of the county in which the facility is located as an urban county (also popularly known as a Lugar county) under section 1886(d)(8)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(8)(B)).”.

(b) TREATMENT OF STANDBY AND ON-CALL COSTS.—Such section 9320(k), as amended by subsection (a), is further amended by adding at the end the following:

“(4) In determining the reasonable costs incurred by a hospital or critical access hospital for the services of a certified registered nurse anesthetist under this subsection, the Secretary shall include standby costs and on-call costs incurred by the hospital or critical access hospital, respectively, with respect to such nurse anesthetist.”.

(c) EFFECTIVE DATES.—

(1) TREATMENT OF CAHS AS RURAL IN DETERMINING CRNA PASS-THROUGH ELIGIBILITY.—The amendment made by subsection (a) shall apply to calendar years beginning on or after the date of the enactment of this Act (regardless of whether the geographic reclassification of a critical access hospital occurred before, on, or after such date).

(2) INCLUSION OF STANDBY COSTS AND ON-CALL COSTS IN DETERMINING REASONABLE COSTS OF CRNA SERVICES.—The amendment made by subsection (b) shall apply to costs incurred in cost reporting periods beginning in fiscal years after fiscal year 2003.

**SA 3078.** Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

**SEC. \_\_\_\_ . YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**

(a) SHORT TITLE.—This section may be cited as the “Young Women’s Breast Health Education and Awareness Requires Learning Young Act of 2009” or “EARLY Act”.

(b) AMENDMENT.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

**“PART S—PROGRAMS RELATING TO BREAST HEALTH AND CANCER**

**“SEC. 399HH. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**

“(a) PUBLIC EDUCATION CAMPAIGN.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women’s knowledge regarding—

“(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

“(B) breast awareness and good breast health habits;

“(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

“(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

“(E) the availability of health information and other resources for young women diagnosed with breast cancer on—

“(i) fertility preservation;

“(ii) support, including social, emotional, psychosocial, financial, lifestyle, and caregiver support;

“(iii) familial risk factors; and

“(iv) prevention and early detection strategies to reduce recurrence or metastasis;

“(2) EVIDENCE-BASED, AGE APPROPRIATE MESSAGES.—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).

“(3) MEDIA CAMPAIGN.—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium determined appropriate by the Secretary.

“(4) ADVISORY COMMITTEE.—

“(A) ESTABLISHMENT.—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and conducting the education campaigns under paragraph (1) and subsection (b)(1).

“(B) MEMBERSHIP.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

“(b) HEALTH CARE PROFESSIONAL EDUCATION CAMPAIGN.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness—

“(A) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

“(B) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

“(C) concerning the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

“(D) on when to refer patients to a health care provider with genetics expertise;

“(E) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

“(F) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer, including—

“(i) re-entry into the workforce or school;

“(ii) infertility as a result of treatment;

“(iii) neuro-cognitive effects;

“(iv) important effects of cardiac, vascular, muscle, and skeletal complications; and

“(v) secondary malignancies.

“(2) MATERIALS.—The education campaign under paragraph (1) may include the distribution of print, video, and Web-based materials on assisting physicians and other health care professionals in achieving the goals of this section.

“(c) PREVENTION RESEARCH ACTIVITIES.—The Secretary, acting through—

“(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

“(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

“(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

“(C) testing and evaluating existing and new social marketing strategies targeted at young women; and

“(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

“(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

“(d) SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.—

“(1) IN GENERAL.—The Secretary shall award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases on issues such as—

“(A) education and counseling regarding fertility preservation;

“(B) support, including social, emotional, psychosocial, financial, lifestyle, and caregiver support;

“(C) familial risk factors; and

“(D) prevention and early education strategies to reduce recurrence or metastasis.

“(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

“(e) NO DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

“(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

“(1) measure—

“(A) young women’s awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women’s proactive efforts at early detection;

“(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors such as tobacco cessation, nutrition, and physical activity;

“(C) the number or percentage of young women receiving regular clinical breast exams; and

“(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

“(2) establish quantitative benchmarks to measure the impact of activities under this section;

“(3) not less than every 3 years, measure the impact of such activities; and

“(4) submit reports to the Congress on the results of such measurements.

“(g) DEFINITIONS.—In this section—

“(1) the term ‘State’ means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, and the Trust Territory of the Pacific Islands; and

“(2) the term ‘young women’ means women 15 to 44 years of age.

“(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated \$9,000,000 for each of the fiscal years 2010 through 2014.”

#### AUTHORITY FOR COMMITTEES TO MEET

##### COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be author-

ized to meet during the session of the Senate on December 8, 2009, at 1:30 p.m.

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

##### COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on December 8, 2009 at 10 a.m. in room 406 of the Dirksen Senate Office Building.

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

##### COMMITTEE ON FOREIGN RELATIONS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 8, 2009, at 2:15 p.m.

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

##### SELECT COMMITTEE ON INTELLIGENCE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 8, 2009, at 2:30 p.m.

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

##### SUBCOMMITTEE ON ENERGY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on Energy be authorized to meet during the session of the Senate in order to conduct a hearing on December 8, at 2:30 p.m., in room SD-366 of the Dirksen Senate Office Building.

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

#### ORDERS FOR WEDNESDAY, DECEMBER 9, 2009

Mr. SANDERS. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, December 9; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation; that following any

remarks of the chair and ranking member of the Finance Committee, or their designees, for up to 10 minutes each, the next 2 hours be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each; the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes, with the remaining time equally divided and used in an alternating fashion; further, that no amendments are in order during this time.

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

#### PROGRAM

Mr. SANDERS. Mr. President, roll-call votes are possible throughout the day tomorrow. Senators will be notified when any votes are scheduled.

#### ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. SANDERS. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 8:38 p.m., adjourned until Wednesday, December 9, 2009, at 9:30 a.m.

#### NOMINATIONS

Executive nominations received by the Senate:

##### DEPARTMENT OF TRANSPORTATION

MICHAEL PETER HUERTA, OF THE DISTRICT OF COLUMBIA, TO BE DEPUTY ADMINISTRATOR OF THE FEDERAL AVIATION ADMINISTRATION, VICE ROBERT A. STURGELL, RESIGNED.

##### IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

*To be brigadier general*

COL. KORY G. CORNUM

##### IN THE ARMY

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

*To be major general*

BRIG. GEN. STEVEN W. SMITH