United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155 WASHINGTON, THURSDAY, DECEMBER 10, 2009 No. 185

Senate

The Senate met at 10 a.m. and was called to order by the Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

PRAYER

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

Let us pray.

Gracious and merciful God, You promised never to leave us alone, and we are grateful for Your comforting presence. Thank You for your whispers of love and peace. Help us to see Your face in others and to show them Your love.

Today, give our Senators the wisdom to know Your will and to choose Your way and purpose. When the choice is between honor and self-interest, help them to do right. May they exercise themselves to have a conscience void of offense toward You and humanity. Lord, give them strength equal to their task, as You undergird them with Your loving providence.

We pray in Your precious Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK L. PRYOR 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).

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, 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.

The bill clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 10, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK L. PRYOR, a Senator from the State of Arkansas, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. PRYOR 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 marks, the Senate will resume consideration of H.R. 3590, the health care reform legislation. The time until 1 p.m. today will be equally divided and controlled and will be for debate only, with the time until 11 a.m. controlled between the two leaders or their designees and the remaining time controlled in 30-minute alternating blocks. The majority will control the first block and Republicans will control the next. Senators will be permitted to speak for up to 10 minutes each.

I expect the House of Representatives to send a conference report to the Senate this afternoon. When it arrives, we will consider it. If cloture needs to be invoked, the Senate will have to be in session this weekend for a Saturday vote and a Sunday vote in order to complete action on these bills. This bill includes the bills we have tried to complete. We have been held up by the minority on these bills, but we have made progress. The first will be the Transportation appropriations bill, Commerce-Justice-Science, Military Construction, Labor-HHS, financial services, and State-Foreign Operations. That would leave the only remaining bill to be the Defense appropriations bill, which we will do sometime before the end of the year. We hope we can get word from the Republicans today what they want to do. Whatever they want to do, it is in their hands.

Everyone should understand that procedurally, no one can stop us from moving to the appropriations bills. It is bipartisan. We have worked closely with Republicans on this matter. We automatically go off the health care bill when we get on this. We are waiting for the score to come back from the Congressional Budget Office. There isn't a lot we can do until we get that done, which would be next week. So no time is lost on health care. We have to complete our work for the year anyway. So we have to do this bill.

Whenever we hear from the Republicans, Senators will know what their schedules can be. We could complete our work today and come back and work something out so that we can have a Monday vote. But whatever the Republicans want, we will be happy to cooperate with them—I shouldn't say whatever they want.

RESERVATION OF LEADER TIME

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

SERVICEMEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The bill clerk read as follows:

A 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.

Pending:

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

Dorgan amendment No. 2793 (to amendment No. 2786), to provide for the importation of prescription drugs.

Crapo motion to commit the bill to the Committee on Finance with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 11 a.m. shall be equally divided and controlled by the two leaders or their designees.

The Senator from Montana.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, let me lay out today's program. It has been 3 weeks since the majority leader moved to proceed to the health care reform bill. This is the 11th day of debate. The Senate has considered 18 amendments or motions. It has conducted 14 rollcall votes. Today, the Senate will continue debating the amendment by the Senator from North Dakota on prescription drug reimportation, we will continue debating the motion by the Senator from Idaho on taxes, and we will continue debate on the bill. Under the previous order, the time until 1 p.m. today will be for debate only, with the time equally divided and controlled between the two leaders or their designees. Beginning at 11 o'clock, Republicans will control the first half hour, and the majority will control the second half hour. We will continue discussions to try to find a way forward.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Mr. President, I appreciate the statistics the Senator from Montana cited about how long we have been debating this and how many amendments we have done. That is how few amendments we have done, actually. The majority is now filibustering their own bill. I have no idea why that is happening. We have been calling for votes on both of these amendments that have been proposed so far and haven't been able to get the votes. I don't understand how they can talk about how many amendments are being done.

I also have to voice some other frustration. I don't know how many times I have heard the exact same speech by the Senator from Illinois, Mr. DURBIN, on this floor talking about the amount of hours that have been spent together working on these bills in the HELP Committee and the Gang of 6 in the Finance Committee. It isn't about how many hours we spend together. It isn't about how many hours we spend on the floor. It is whether we are accepting ideas. I understand the other party won the last election, but somehow they will have to get over this attitude that they won the election, they get to write the bill, they don't have to take any ideas from anybody else.

In the HELP Committee, I keep pointing out that most of the things we turned in were kind of punctuation corrections and spelling corrections. Any ideas we actually had that appeared to be accepted to be in the bill were ripped out of the bill before it was actually formally printed, without talking to us. What kind of bipartisan deal is that?

Another thing with the HELP Committee, we have only had 10 days of debate on this. We did more than that in the HELP Committee when we were marking up the bill.

But we are having, in the words of Yogi Berra, déjà vu all over again. When we were having that markup, the majority withheld a significant part of the bill, a big part of the bill. It was the government-run option part of the bill. They wouldn't give us the wording on that. I think they were still writing it. Maybe that is what is happening right now too. But we couldn't get the text we were going to write amendments on so that we could deal with the bill. I think America noticed that in August. People said: How come everybody isn't reading the bill? You can't read what you don't have.

The point I am making is, right now the newspapers are full of information—well, speculation; it has to be speculation—about what this new Medicare expansion does. I haven't run into anybody who has seen the text of that. I have asked some of the media, and they didn't see the text. They got a briefing. We haven't even had a briefing. The majority side has had a briefing, but our folks who have talked to those folks said: Wow, that was pretty general. How could you make up your mind on whether you are going to support it based on the little bit of information you received? That is not the way to run any kind of an organization, especially if you want bipartisan votes.

You can't write the bill in secret, which is what was done with this bill. There wasn't a Republican involved in the behind-the-door stuff Leader REID did to put together the bill we have now. That is not bipartisan. There

hasn't been a single person from the Republican side briefed on this new proposal that is going to save the world.

Actually, I noticed that the American Medical Association suddenly left the bill and said: This will be the worst thing that could happen to us. The hospital associations, which have been strong supporters of the bill, have also said this won't work, particularly the Mayo Clinic, which we have been holding up as one of the prime examples of the way to do health care, saying: If this Medicare expansion happens, it will cost us millions. We won't be able to provide the kind of care we have been providing.

What is the deal around here? When are we going to actually get to see something? When is the majority actually going to share with us this marvelous idea they have had? What kind of a way to run a business is that?

Are we going to recess for the weekend? I don't want to recess for the weekend. I am conscious of the 11 days we have been debating, and we have only covered 14 amendments. We have a lot of important amendments that either will be a part of the bill or will help the people in this country to understand what is being thrust on them. There has never been a bill of such importance as this one from the standpoint of how many people it affects. We are talking about reforming health care in America. That is everybody. That is every single individual, every single provider. Every single business will be affected by this bill.

We talk about 2,074 pages, which seems like a lot. It would be for a normal bill that you could debate in a limited period, which is what we are being asked to do. But 2,074 pages isn't nearly enough to cover health care for America.

So why is it only 2,074 pages? There are hundreds of references in there to how the Secretary of Health and Human Services is going to solve all the problems. The things we aren't able to put into detail in there we just assign to her, and she will magically be able to solve the problems for American health care. After all, it is her Department. But that is not going to happen. You can't give that many assignments to any agency, any department, any group of people and expect them, in a reasonable amount of time, to come up with solutions, solutions that ought to be decided on by this body, the elected officials—not appointed officials but elected officials. That is not going to happen with this bill.

The only way that could happen is if we took significant parts of it and put it up one piece at a time and solved it. That is what seniors are asking for. They are asking for us to take the Medicare part and give them some assurance that when we are through, it will work. We are not even getting to see a significant part of it. We have been pointing out how taking $464 billion out of Medicare will break it, will ruin it. You just can't steal $464 billion out of Medicare and have it come out good. The majority recognizes that. That is why they put in the special commission that is going to come to us each and every year and suggest the kinds of cuts we ought to make to keep that solvent.

The biggest thing we ought to do is take these cuts that are provided and make them actually apply only to Medicare. But how are you going to fund the expansion of Medicare now down to age 55? How do you do that? I guess you charge a premium to those people. That is kind of the rumor that is out there. How big of a premium? How big of a premium are you going to thrust on those people? I suspect it is going to be the older and the sicker people in that 55- to 64-age category who are going to want to shift over to Medicare.

If it is a higher premium so the system stays solvent—having nothing to do, of course, with age, because we cannot do that under the bill, or sickness, because we cannot do that under the bill—and those are good ideas—but those better be up in that range of the high-risk pools that the States already have.

People come to me and say: You have to do something about health care because we cannot afford that high-risk pool; it is too expensive. Well, how much more are we going to expect the young people to pitch in in their paycheck? That is where the Medicare money comes from right now. They deduct a portion of the paycheck from every single working American, and that goes into Medicare, and gets paid out right away to Medicare recipients, none of whom or hardly any of whom are the ones paying into the system. They are hoping that system is going to be there when they get older.

What I am asking for is for the majority to show us the paper and give us a reasonable time to look at it and give America a reasonable time to look at it. I do not think it is unreasonable for that to be on the Internet. That is a significant part of the bill. That would be a significant bill all by itself. It was held from our view when the HELP Committee did it. Incidentally, that HELP Committee bill—that was put together in 2 weeks without our help and put on us—parts of it were withheld, as this has been withheld, until the last minute and then thrust in.

That is what created this enormous outrage across America of: Did you read the bill? How can you read the bill if you have not seen anything in it, if it has not been given to you? I do not think it is intended to be given to us until we have to shuffle this thing through at the end.

The anticipation was to get this done by Christmastime, and the majority side keeps talking about getting this done by Christmastime. Will we have time to read it before Christmastime? Will we have a chance to do any amendments on it before Christmastime? I am willing to stay around and work through the weekend and keep doing amendments, but I would like to see this marvelous idea that is going to solve the whole problem. If it was that marvelous and that good of an idea, I think it would be shared already.

Mr. President, I yield the floor and reserve the remainder of our time.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum and I ask unanimous consent that the time be equally charged against both sides.

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

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. BAUCUS. Mr. President, commenting on the budget process in the 1980s, former CBO Director Rudy Penner said:

> The process is not the problem; the problem is the problem.

The chairman and ranking member of the Budget Committee have proposed another new budget process. No one has shown greater zeal in taking on the budget deficit than the chairman and ranking Republican Member of the Budget Committee. I commend their good intentions. They work hard. But we should reject this process. Instead, we should solve the problem.

In their press release yesterday, Senators CONRAD and GREGG said that ''Everything needs to be on the table, including spending and revenues.'' That is a quote: ''Everything needs to be on the table, including spending and revenues.'' But why stop there?

If Congress is going to outsource its core fiscal responsibilities, why stop with those responsibilities? Why not cede to this Commission all of the legislation in the next Congress? Why don't we outsource the entire year's work and then adjourn for the year?

Come to think of it, if we do cede all of our powers to this Commission, what is to stop them from inserting any and all business for the next Congress into the Commission's one, nonamendable, omnibus vehicle? No restrictions. They could put anything they want into it.

There is the rub. For if the Commission were merely a farce, then we could be satisfied with ridiculing it. But this Commission and its new fast-track process are truly dangerous. If we were to cede all of our responsibilities to this Commission, and we were to tie our hands so we could not amend its recommendations, then we would risk setting in motion some truly terrible policy.

Under the proposed fast-track procedures, we would not be able to amend the proposal. What if we did not like

the Commission's recommendations? We would not be able to replace the Commission's recommendations with our own.

It is clear from their press release that Senators CONRAD and GREGG have painted a big red target on Social Security and Medicare. That is what this Commission is all about. It is a big roll of the dice for Social Security and Medicare.

Advocates of the task force say the regular order is not working. They say we need a new process to address our long-term fiscal challenges. But they are wrong. The regular order is working. We are enacting health care reform. And serious people know that controlling the costs of health care is the central path to addressing our long-term budget challenges.

The lion's share of the reason why deficits are projected to grow so much in the long run is the enormous increase in the costs of health care. We are doing something about it. We are doing it the right way. We held open hearings. We legislated in committee. We are voting on amendments. We are legislating. We are doing what our people back home sent us here to do.

The Congressional Budget Office says that health care reform will cut the deficit $130 billion in the first 10 years and $650 billion in the second 10 years. That is nearly $800 billion in CBO-certified deficit reduction in health care alone. And next year we will legislate fundamental tax reform.

But some appear to want to throw in the towel. Some want to punt our responsibilities away. I can see that a commission may be attractive to some. After all, it is an easy way out. It takes away our accountability for what we do. Senators can blame it all on the Commission. Senators could say: The Commission made me do it.

But this is no time to abdicate responsibility. This new Commission and this Congress are less than a year old. We should not shirk our responsibility. Rather, we should do the job our constituents sent us here to do.

Luckily, we already have a process to address the budget. It is called the congressional budget process. Here is a novel idea: Why don't we use the budget process to address the budget deficit? If the chairman and ranking Republican Member of the Budget Committee are in such broad agreement on their goals, why don't they skip the Commission and go straight to their recommendation? That is exactly why Congress created the budget resolution and the reconciliation bill in the first place.

We do not need a new commission to do our work. We do not need a new process to solve the problem. To solve the problem, we just need to solve the problem.

I urge my colleagues to reject this Commission idea. Let's get back to solving the problem. Let's get back to enacting real health care reform.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Mr. President, I am fascinated by the speech we heard. There has been a bipartisan proposal. The chairman of the Budget Committee and the ranking member of the Budget Committee have proposed a commission, and that bipartisan deal is being chastised here. So we are on the bill, where 64 percent of the amendments that have been filed so far were filed by the Democrats, and I keep wondering why they are filibustering their own bill.

Then when something bipartisan does come up, they are opposed to that too. I know they think the only good ideas come from the other side of the aisle, and I do get frustrated with that.

Mr. BAUCUS. Mr. President, will the Senator yield on that one point? Just on that one point, will my good friend from Wyoming yield, on our time?

Mr. ENZI. Certainly.

Mr. BAUCUS. The question is this: Doesn't the Senator agree—it is kind of a hard question to ask—that this Senator spent an inordinate amount of time in the last year trying to get a bipartisan solution to health care reform; that is, in our committee, in the Finance Committee, having an open process, fully consulting on both sides of the aisle? Then we had that other group called the Group of 6, of which the Senator is a part. I think we had 130—I have forgotten how many days and meetings we had, how many hours we met.

But isn't it true that at least this Senator tried as hard as he could to get a bipartisan solution?

Mr. ENZI. I cannot fault the Senator from Montana for his efforts to get a bipartisan solution. As I have said many times, I am sorry he had to be cut off by phony time deadlines that kept us from reaching that kind of a solution, and then winding up with things that are in this bill we are talking about that were not a part of our discussions—again, the things that were proposed by people on this side of the aisle that are not in that bill.

There were some possibilities for solutions. But we wound up with that same situation of: We won the election, we get to write the bill, and it has to be done quickly. So I am disappointed in the whole process.

Mr. GREGG. Will the Senator yield for a question on that point?

Mr. ENZI. I will.

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

Mr. GREGG. I certainly respect that the Senator from Montana worked very hard to have a bipartisan initiative here, but this bill we are dealing with has no bipartisanship to it at all. Was this not written in camera behind closed doors for 8 weeks by the majority leader? Was there a Republican in that room at any time? And we have now been on it for what, 8 days or something, while they wrote it for 8 weeks. And furthermore, is there not rumored to be floating around this Congress somewhere, in some room, again—that we have not been invited to—a major rewrite of this bill called the managers' amendment, which supposedly is going to expand coverage to people under Medicare to 55 years of age, with Medicare already being bankrupt, and already cannot afford the people they have on Medicare? It is going to expand it. We have not seen it. Yet this is going to change this bill fundamentally and change health care fundamentally.

Is that bipartisan? I ask the Senator from Wyoming if that is the case? Was this bill written in a bipartisan manner? Were any Republicans in the room? Did it go through a committee process? Was it amended? Did it not take 8 weeks to write it, and it has now been on the floor for 8 days, and all of our amendments are being pushed to the side? And are we not hearing about a massive—a massive—rewrite of this bill that is going to appear deus ex machina from the majority leader's office and fundamentally change the way health care is delivered in this country? Is that going to be bipartisan?

Mr. ENZI. The Senator is absolutely right. We have not even seen this new piece. Nobody wants to show us the new piece. They keep talking about it. They have leaked it to the newspapers, but they will not show it to us, and then they keep talking about how this bill is going to solve the deficits for this country; that there is $157 billion or something saved in the first 10 years. That is only—only—if you use the phoney accounting they are using. It is only if you don't do the doc fix. It is only if you don't solve the myriad of other things we have brought out.

We have a bill they keep talking about as being the solution. America has figured it out, but the Democrats haven't figured it out.

I see the leader is on the Senate floor. I yield the floor.

RECOGNITION OF THE MINORITY LEADER

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

Mr. MCCONNELL. Mr. President, I apologize to my colleagues for interrupting their conversation. Hopefully, it can continue upon completion of my remarks, and I may well wish to join in.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, the American people have seen what Democrats in Congress plan to do with seniors' health care. They have looked on in disbelief as almost every Democrat in the Senate voted again and again and again to slash Medicare. Now they are watching in disbelief as Democrats float the idea of herding millions more—millions more—into this nearly bankrupt program as part of a backroom deal to force their plan for health care on the American people by Christmas.

Every day it seems we hear new revelations about secret conference room deliberations where Democrats are

frantically working to get their 60 votes by Christmas. And every day we hear about some new idea they have come up with for creating a government plan by another name. This week's version would have the Office of Personnel Management running the program, an idea that was shot down almost as soon as it was announced by the former OPM Director who said it couldn't be done.

This is what he said: ''I flat out think that OPM doesn't have the capacity to do this type of role.''

This is precisely the kind of approach Americans are tired of in Washington, and this is precisely the kind of health care plan Americans did not want.

Seniors thought they could expect lower costs. What they are getting instead is an assault on their Medicare. Small business owners thought they could expect lower costs. What they are getting instead are higher taxes, stiff fines, and costly mandates. Working Americans thought they would get more efficiency, less fraud, cheaper rates. What they are getting instead are new bureaucracies and higher costs.

Business leaders from across the country enthusiastically support the idea of health care reform. They know better than anyone that costs are out of control and that something needs to be done. But they have read the bill Democrats in Congress have come up with and they are telling us this isn't it. This isn't it, they are saying. Not only won't this bill solve the problem, they say, it makes the existing problems actually worse.

The Vice President of the U.S. Chamber of Commerce was here yesterday. He said there is a desperate need for reform—reform that bends the cost curve down. He said, unfortunately, this bill fails the test. He says this bill will only lead businesses to lower wages, decrease working hours, reduce hiring, and cut jobs. He said it adds to the deficit; it adds to the debt. It includes massive new spending programs and entitlements and incredibly, as I have noted, it also borrows from existing entitlement programs. It borrows from existing entitlement programs that are already in trouble.

Businesses look at this bill and they see $½ trillion in new taxes, as many as 10 million employees at risk of losing coverage, and crushing new mandates. This is not reform. This bill doesn't solve our problems, it spreads them. That is why seniors don't like this bill. That is why job creators don't like this bill. That is why public opinion has dramatically shifted against this bill.

Americans want reform, but this is not the one they asked for. This bill is fundamentally flawed and it can't be fixed. There is no way to fix this bill.

Americans want us to stop, they want us to start over, and they want us to get it right. Democrats should stop talking at the American people and start listening to them.

Now, Republicans are prepared to provide a platform for the debate as long as it takes—as long as it takes. The majority leader said we would be working every weekend. We take him at his word. We expect to be here this weekend, and we look forward to it. Republicans are convinced there is nothing more important we could do than to stop this bill and start over with the kind of step-by-step reforms Americans really want.

We have amendments. We want votes. We have been waiting since Tuesday to have more votes. We are eager to continue the debate.

Here is what my good friend, the majority leader, said when we started the debate on November 30:

> Debating and voting late at night. It definitely means the next weekends—plural—we'll be working. I have events I'll have to postpone, some I'll have to cancel. There is not an issue more important than finishing this legislation. I know people have things they want to do back in their States, and rightfully so. I know people have fundraisers because they're running for reelection. I know there are other important things people have to do, but nothing could be more important than this, and we notified everybody prior to the break that we would be working weekends.

We took the majority leader at his word when we started this debate on November 30 that we would be working weekends. Actually, it is a week later—this past Monday of this week—he said, ''It appears we certainly will be here this weekend again.''

My Members understood we would be here on the weekends. We don't think there is anything more important we can do, and we are a little bit upset—maybe more than a little bit—that we were not able to vote on an amendment yesterday. We have been prepared to vote for several days. There are amendments that have been offered that we can't seem to get a vote on. The American people are expecting us to vote on this bill, and we are here and prepared to do it. We would like to get started voting on amendments today.

Mr. GREGG. Mr. Leader, if I might ask a question through the Chair.

The PRESIDING OFFICER (Mr. BENNET). The Senator from New Hampshire.

Mr. GREGG. On that last point, it does seem there is a slowdown occurring on amendments. As I understand it, we have four or five very substantive amendments dealing with taxes, dealing with employer mandates, that we are ready to go to, and we are ready to vote on; is that not correct?

Mr. McCONNELL. I say to my friend from New Hampshire, that is absolutely the case. We waited around all day to get a vote on the amendment by the Senator from Idaho, Mr. CRAPO. We were told there would be a side-by-side, and it mysteriously has not yet appeared. But we are here ready to work. We share the view of the majority leader that this is an extremely important issue, and we want to vote.

Mr. GREGG. I hope at some point today maybe we should propound a unanimous consent setting those four items up for votes on Saturday and Sunday.

Mr. McCONNELL. Well, I think that is a good idea. Of course, we would prefer to vote today. We are going to be voting Saturday and Sunday too. I think the sooner the better. The American people are actually expecting us—they thought we were here voting and debating amendments on this bill, and we are going to continue to press forward and try to get that done.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, could I inquire of the Chair before the Senator from North Dakota speaks how much time remains.

The PRESIDING OFFICER. The majority has 14 minutes, and the Republicans have just under 8.

Mr. GREGG. Mr. President, I would ask, is the Senator from North Dakota recognized under an order of a colloquy at this point?

The PRESIDING OFFICER. The Chair simply recognized the Senator from North Dakota.

Mr. CONRAD. Mr. President, was there a time reserved for a colloquy between myself and the Senator from New Hampshire?

The PRESIDING OFFICER. No.

Mr. CONRAD. Mr. President, the reason we are here on the floor is our understanding was we had time reserved at 10:30 for a colloquy between the Senator from New Hampshire and myself.

Mr. GREGG. Mr. President, I ask unanimous consent that we have 20 minutes equally divided between myself and the Senator from North Dakota at this time. I see the Senator from Connecticut obviously wishes to speak also.

Mr. DODD. Mr. President, I was not a party to the request, but I am certainly prepared to yield 10 minutes of our time to our colleagues for a colloquy and whatever time the Republican side may want to yield to Senator GREGG from their time remaining for that purpose as well. Is that satisfactory?

Mr. GREGG. Do we have time remaining on our side?

Mr. DODD. Mr. President, I ask unanimous consent that 10 minutes of our time be allocated to Senator CONRAD for the purpose of a colloquy or whatever other purpose he may have.

Mr. CONRAD. Do the Republicans have 10 minutes remaining for Senator GREGG?

Mr. ENZI. Mr. President, it is my understanding the leader spoke under leader time.

The PRESIDING OFFICER. That is correct.

Mr. ENZI. So we should have an adequate 10 minutes to allocate to the Senator.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senators may engage in a 20-minute colloquy.

Mr. CONRAD. I thank the Chair. I thank our colleagues. I especially thank our colleague, the Senator from Wyoming, and our colleague from Connecticut. Thank you for your courtesy. We appreciate it very much.

Mr. President, this is a headline from Newsweek, December 7. In fact, it was the cover story: ''How Great Powers Fall. Steep Debt, Slow Growth, High Spending Kill Empires—and America Could Be Next.''

If you go to the story—by the way, interestingly enough, this was on December 7, Pearl Harbor day. If you go into the story that is in the magazine, it says:

> This is how empires decline. It begins with a debt explosion. It ends with an inexorable reduction in the resources available for the Army, Navy, and the Air Force. If the United States doesn't come up soon with a credible plan to restore the Federal budget to balance over the next 5 to 10 years, the danger is very real that a debt crisis could lead to a major weakening of American power.

All we have to do is look at the facts. This shows the debt of the United States from 2001 projecting to 2019. Obviously, the first half of this chart is not a projection. It has already happened. We are approaching a debt that is 100 percent of the gross domestic product of the United States, the highest the debt has been since after World War II and the only time in our Nation's history it has been that high. The projection is by 2019 the debt will be high. The projection is by 2019 the debt will be 114 percent of the gross domestic product of the United States.

More alarming, the long-term outlook of the Congressional Budget Office says we will have a debt that will reach 400 percent of the gross domestic product of the United States by 2050 on the current trend line. No one believes that is a sustainable circumstance. We have had testimony from the head of the General Accounting Office, the Congressional Budget Office, the Secretary of the Treasury, and the Chairman of the Federal Reserve all saying this is a completely unsustainable circumstance.

The Congressional Budget Office said this in June of 2009:

> The difficulty of the choices notwithstanding, CBO's long-term budget projections make clear that doing nothing is not an option.

Doing nothing is not an option.

The National Journal, in an article entitled ''The Debt Problem is Worse Than You Think'' said this in a story just weeks ago:

> Simply put, even alarmists may be underestimating the size of the debt problem, how quickly it will become unbearable, and how poorly prepared our political system is to deal with it.

I hope people are listening. I hope they are paying attention. I hope our colleagues are.

Yesterday a group of us introduced legislation to confront this debt threat head on. There are now 31 cosponsors of that legislation: 19 Republicans, 12 Democrats. This legislation offers the following: to address the unsustainable long-term fiscal imbalance; that a task force should be created with everything on the table. It would consist of 18 Members: 8 Republicans from the Congress, 8 Democrats from the Congress, and 2 representatives of the administration.

All task force members must be currently serving in Congress or the administration so they are accountable to the public. If 14 of the 18 Members could agree on a report, that report would come to Congress for a vote.

There would be no filibustering, a straight up-or-down vote on the recommendations. The report would be submitted after the 2010 election to insulate it from politics. And, the vote would be designed to occur before the end of the 111th Congress. It would receive fast-track consideration in the Senate and the House. There would be no amendments. It would be a straight up-or-down vote. A supermajority of the House and the Senate would have to vote for it, and the President would retain his ability to veto.

This is legislation that is designed to get to the floors of the House and the Senate, legislation to deal with our long-term debt threat, to face up to it. All of us know that with a problem, the sooner you deal with it, the less draconian the solutions need to be. For those who say this poses a threat to Social Security and Medicare, the opposite is true. A failure to act is what threatens Social Security and Medicare.

The trustees of Medicare have told us Medicare will go broke in 8 years. They have also told us Medicare is cash negative today. That means more money is going out than is coming in. The same is true of Social Security today. It is cash negative.

Now is the time. We are the ones who have an opportunity to help our country face up to a critical threat to the economic security of America. Some suggest the bill before us on health care is an example that the regular order will deal with this problem. Again, I believe the reverse is true.

I believe the health care bill before us does modestly deal with the deficit and debt—modestly. But it doesn't come close to dealing with the debt bomb I have outlined. In fact, the reality is, we are on a course that is absolutely unsustainable. It is our responsibility to face up to it.

In our past, we have chosen special processes, commissions, a summit, or some other special process to deal with fiscal challenges because we have learned, in our history, that going through the regular process and regular order is simply not going to succeed.

I have been here 23 years. I am on the Finance Committee. I am chairman of the Budget Committee. I have been on those committees for many years. If there is one thing that is absolutely clear to me, it is the regular order cannot and will not face up to a crisis of this dimension. It is going to take a special process, a special commitment of the Members and representatives of the administration to develop a plan that gets us back on track. It is going to take a special process to bring that plan to this floor for a vote up or down. That holds, I believe, the best prospects for success.

I believe this is a defining moment for this Chamber, for this Congress, for this administration. It is imperative that we find a way to deal with this debt threat. It poses one of the most dramatic challenges to American economic strength that we have confronted in the history of this country. It is time to stand and be counted.

Thirty-one of us have sent forward a proposal—a bipartisan proposal—that would assure a vote on a plan to bring America back from the brink. Let's give it a chance.

I thank the chair, and I especially thank the ranking member, Senator GREGG, for his energy, his commitment, and his devotion to facing up to, I believe, one of the greatest challenges confronting America.

I yield the floor.

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

Mr. GREGG. Mr. President, I am privileged to join the Senator from South Dakota, the chairman of the Budget Committee, on this initiative. We have worked on it for a while, and we have come to a position of having a piece of legislation that accomplishes the goal as outlined by the Senator from North Dakota. That is good news.

The outpouring of support in the Senate—over 31 cosponsors in just a brief period of time—is a sign that there is a willingness to move in a bipartisan way. That is good news.

Right now, for this country, after the possibility of a terrorist getting a weapon of mass destruction and using it against us in the United States, the single biggest threat we have as a nation is the fact that we are on course toward fiscal insolvency. You cannot get around it. If we continue on the present course, this Nation goes bankrupt. We are already seeing the early signs of it. The early signs are devastating enough. We are seeing some of the nations who lend to us—and remember we are a debtor nation now of massive proportions—saying: Hold on, you folks are not being responsible, especially about your outyear debt.

Two days ago, we saw one of the rating agencies, Moody's, say England and the United States now are going to be put into a special category relative to the rest of the industrialized world because their fiscal situation is in such risk, and they are not managing their fiscal house correctly.

We know, as the Senator from North Dakota has outlined so correctly, that within 10 years—maybe sooner—we are

going to get to a point where our debt has gotten so large we simply cannot pay it or, if we have to pay it, we are going to have to do some extraordinary things to do that, such as inflating the currency or raising taxes to a level where we reduce productivity and the opportunity for jobs. It is akin to a dog chasing its tail when you get your debt to a certain level. When you have spent so much more than you have taken in and you have promised so much more than you can afford to pay and your debt gets to such a level, as a nation, you only have two choices: You inflate the currency and destroy the quality of people's lives, destroying the value of their savings, and you put in an inflation economy, which is one of the worst things that can ever happen to a country or you have to radically increase your tax burden to levels that are simply going to choke off the capacity of the Nation to create prosperity because people will not be able to be productive. You will start to lose tax revenues as a result of that.

This is not a theoretical case. This is no longer something that is over the horizon. This problem is directly in front of us. We are hearing it from the people who lend us money, from the rating agencies, and we know it from intuitive common sense. Most Americans know this is an extraordinary problem.

We talked about this for a long time and we worked on it for a long time. Yes, regular order should take care of this, but we know it will not because we have seen what happens. When you put an idea on the table to deal with major entitlement programs that affect so many people, in such a personal way, immediately, those ideas are attacked and savaged, misrepresented, exploited, exaggerated, and hyperbolized by the interest groups that populate this city and other parts of the country for the purpose of making their political agenda move forward or their money-raising formula move forward.

When substantive, good ideas have been put on the table to try to correct this fiscal imbalance by dealing with questions of Social Security and Medicare or tax policy, we get clobbered on the policy side. We came to the conclusion from the right and the left that it is equally outrageous and equally destructive of constructive public policy. We came to the conclusion that the only way you can do this is to create a process that drives the policy, rather than put the policy on the table first, saying here is the policy and everybody jumps on it and kicks it and screams at it and so it never even gets to the starting line. We decided let's get to a process that leads to policy and leads to an absolute vote.

The theory is, basically, threefold: One, the process has to be absolutely fair and bipartisan. Nobody can feel they are being gamed. The American people will not allow major policy to occur in these areas unless they are comfortable the policy is bipartisan and fair. So this process we have set up is a bipartisan affair. There will be 18 people. We decided to go with people who actually have a responsibility for making decisions and understand the issues intimately; 16 from the Congress, as was mentioned—8 Republicans and 8 Democrats—and the 2 from the administration, with a supermajority to meet, to report, and there will be co-chairmen from each party. That gives us the bipartisan nature.

The second part that is critical to the exercise is that it be real and that it not end up being a game. We have seen so many commissions end up being just commissions. They put their report out and it ends up on a shelf somewhere.

Something has to happen. What happens is, when this Commission reports with a supermajority and comes to Congress, by supermajority it must be voted up or down. So there is an absolute right to a vote, and the vote occurs on the policies proposed. That is critical. It is much along the lines of what we did for base closures, for many of the same reasons. You couldn't close bases politically, so we did it by fast-track approval.

Third, there will be no amendments. Why? Amendments allow Members to hide in the corners. It is that simple: Somebody throws an amendment up—even if it is well intentioned—and people vote for the amendment and then say it didn't pass or I will not vote for the final product. You have to have a policy put forward, and it will either attract a bipartisan supermajority and be a fair policy or it is not. If it doesn't attract a bipartisan supermajority, clearly, it wasn't well thought out.

That is the process we have come to. The amount of sponsors we have reflects the fact that it is viable and that it is bipartisan. We have 12 Democratic sponsors already and 19 Republicans. What else around here has that with serious legislation? This is it.

I congratulate the Senator from North Dakota for his efforts. I am hopeful we can get a vote on it. Then, I hope it can pass, and I am hopeful we can get White House support and House support to do this.

We are running out of time. If we don't accomplish this fairly soon, the outcome is very simple: We will pass on to our children less opportunity, a lower standard of living, and a weaker Nation than we received from our parents. No generation in American history has done that. But that is what we are going to do if we don't take action. That is exactly what is going to happen. How can one generation do that to another? In American history, that has never happened. This is an opportunity to avoid having that occur or at least help avoid it. I hope it will move forward.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

Mr. CONRAD. Mr. President, how much time remains of the 20 minutes?

The PRESIDING OFFICER. Two minutes 40 seconds.

Mr. CONRAD. How much on my side?

The PRESIDING OFFICER. The time is equally shared.

Mr. CONRAD. Let me sum up by saying this: I have been here 23 years. We saw the debt double in the previous 8 years. We know the debt is scheduled to more than double over the next 8 years if we fail to act. That will be a debt, as I indicated earlier, of well over 100 percent of the gross domestic product of the United States.

The Congressional Budget Office tells us, on the current trend line, we are headed for a debt that will be 400 percent of the gross domestic product of the United States. That is absolutely beyond the pale. We know, from every serious expert who advises the Congress of the United States, we can't go there. We can't possibly be on a course to have a debt that is 400 percent of the gross domestic product of the country.

The question is, What do we do about it? There are some who say: Well, you stick with the status quo approach. It hasn't worked so far. Why is there any reason to believe it will work now? I would say the health care legislation before us is a perfect example. The President had a health care summit; he had a fiscal responsibility summit. At those summits, it was asserted—and I think it was well intended—that health care reform would deal with a major part of the debt projection facing us. Well, here we are. My belief is, this bill does modestly reduce the deficit in the short- and long-term. But it in no way deals with the trajectory that is headed for a debt of this country of 400 percent of the GDP, because when you are in this circumstance, the regular legislative process cannot face up to short-term pain in exchange for long-term gain. It will not do it. This is our opportunity. We must act.

I thank the Chair.

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

Under the previous order, the time until 1 o'clock will be controlled in 30-minute alternating blocks, with the majority controlling the first block and the Republicans controlling the second 30 minutes.

The Senator from Connecticut.

Mr. DODD. Mr. President, before my colleagues from North Dakota and New Hampshire leave, let me commend them for their efforts in this regard. There may be debates about the details of this legislation.

One of the first amendments I ever offered, sitting back in the far corner, as a freshman Member of this body was a pay-as-you-go budget in the Reagan administration. Then I was a cosponsor of Gramm-Rudman-Hollings back in 1985—that was 24 years ago—which was an effort to try to put some restraints on the exploding process at the time.

While I am not prepared necessarily to sign on this morning, I would be remiss if I did not thank them for their efforts. And either something like this

or a variation of it is needed so there is some process in place to allow us to deal with these issues.

Before they wandered off and we were back on the health care debate, I wanted to thank them for their efforts.

Let me once again address issues that need to be clarified. We have disagreements about the health care bill.

I want the record to reflect the efforts that have been made for over a year now to involve our colleagues across the spectrum, beginning with my predecessor, Senator Kennedy, who would be otherwise standing at this very podium but for his illness and his death. My office and his staff worked closely together and I want to share the details of those meetings that occurred beginning about a year ago to formulate the very bill we are grappling with today. I was not a participant in those early meetings. Senator Kennedy was, with his staff and Members of the minority staff right after the elections. I began to work in his place starting around the first of the year or shortly thereafter.

There were numerous meetings between Members from across the spectrum from the Budget Committee, the Finance Committee, the HELP Committee, countless meetings of staff in all three of these committees. Many of them occurred in Chairman BAUCUS's office, the chairman of the Finance Committee.

Battling over the substance of the bill is a very legitimate process. There are 100 of us representing various constituencies and various ideas. There is nothing inherently wrong about that. In fact, it is a healthy process to go through. But I cannot stand here and accept the notion that people have been excluded from the process. That is not the case at all.

There are times when the majority, who has the responsibility to pose ideas, will meet together to formulate an idea or a series of ideas to bring forward. To say this is a historical, unprecedented occurrence defies what anyone who has known 5 minutes of the history of this institution knows. I recall only a few years ago when the minority leader and others were excluded from conference meetings between the House and the Senate. If Tom Daschle showed up, the word was, the conference committee would be canceled. Imagine, the minority leader, a conferee, dealing with the House and Senate, would show up and the meeting would be canceled. With all due respect, it is that old line of Claude Rains in the famous movie ''Casablanca,'' walking into Rick's Café, looking around with Humphrey Bogart there and saying: ''Is there gambling going on here? Shocking.'' Is politics going on in the Senate? Yes, it is. And it has back to 1789, to the founding of the Republic. Politics has happened in this institution where people try to formulate ideas to bring together on behalf of our constituents across the country.

It needs pointing out, as I will, and I will lay out and provide shortly every single amendment offered by the other side—hardly technical, so everybody can read them—the provisions in this bill that were specifically offered by Members of the minority that were accepted either in our committee or in other places and are reflected in the substance of this bill.

Is it their bill? No. Obviously, they have not voted for it. But a lot of the substance in it is theirs, and to suggest otherwise is not true. The notion that people have been excluded from this process is just not the case at all. In fact, going back, if you will, since January of 2007 the HELP Committee has held 30 bipartisan hearings on health care reform, with 15 alone in 2009. Taken together, the HELP and Finance Committees held more than 100 bipartisan meetings. Beginning in December 2008, the bipartisan leadership of the HELP Committee, the Finance Committee, and the Budget Committee met 10 times to discuss health care reform legislation. Staff met even more frequently. Ideas discussed in those meetings are reflected in this bill. In 2008, the HELP Committee held 15 bipartisan health reform staff roundtables, which included Republican and Democratic staff from the HELP, Finance, and Budget Committees. Over 80 stakeholders from the pharmaceutical industry, the insurance industry, those who advocated single-payer approaches—80 stakeholder meetings were held in the health care debate from across the political spectrum. Democrats, Republicans, patients, providers, employers, unions, insurers, and drug device manufacturers contributed recommendations to this bill. They were not all accepted. The idea that we would take everyone's idea that comes to the table is ludicrous on its face. But certainly the opportunity to affect the outcome of this bill was very much an open process.

In addition, committee staff held regular meetings with smaller representative groups. Since April of 2009, these meetings have included staff from Senator ENZI's office, Senator GREGG's office, and Senator HATCH's office. These meetings included groups from across the political spectrum who met for 2-hour sessions twice a week to provide detailed and thoughtful contributions to this bill.

In addition to these stakeholders, hundreds of groups attended larger stakeholder meetings on March 13 and May 15 where further recommendations on reform were heard.

On June 10 and 11, prior to beginning of the markup of the HELP Committee bill, Members had detailed, bipartisan discussions of the draft legislation, including extensive options contributed by our Republican colleagues. Options provided by Republican Members were reflected in the legislation approved by the committee.

On June 22, HELP Committee Senators also met with the nonpartisan Congressional Budget Office Director Doug Elmendorf and other CBO staff.

The markup in the HELP Committee lasted almost a month—a record for that committee, by the way. The committee held 56 hours of executive consideration of the legislation, stretching across 23 different sessions over 13 days. Taken together with the Finance Committee, more than 20 days were devoted to the amendment process alone. During the HELP Committee markup—I have mentioned this over and over again—we considered 287 amendments, almost 300 amendments, and 161 of those 287 were accepted Republican amendments.

I ask unanimous consent to have printed in the RECORD all of those amendments that were accepted and the description of those amendments.

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

HELP and SFC Republican Amendments in the PPACA

HELP/ SFC	AHCA/AHFA Title	AHCA/AHFA Amendment	Page in PPACA	Line on Page	Amendment Purpose
HELP	I	Burr 202	200	7	To apply the same laws to private plans and the community health insurance option.
HELP	I	Burr 217	184	9	To provide for the application of certain State laws to the public plan
HELP	I	Burr 235	31	3	To strike provisions that prevent a full accounting of costs.
HELP	I	Burr 242	142	6	To limit the use of Gateway surcharges
HELP	III	Burr 5	1166	15	To require all services to be age appropriate under the school-based health clinic program
HELP	III	Burr 6	1143	23	To require the Preventive Services Task Force to consider clinical preventive best practice recommendations
HELP	I	Coburn 225	367	7	To provide that no insurer shall be required to participate in any Federal health insurance program.
HELP	I	Coburn 226	156	6	To require Members of Congress and congressional staff to enroll in a Federal health insurance program.
HELP	I	Coburn 228	195	7	To require the use of available technologies to reduce and help prevent waste, fraud, and abuse.
HELP	I	Coburn 229	364	21	To ensure taxpayers are not forced to fund assisted suicide.
HELP	I	Coburn 231	143	1	To provide for a full accounting of costs.
HELP	I	Coburn 237	364	21	To ensure health care providers are not forced to participate in assisted suicide or discriminated against because they choose not to participate in assisted suicide.
HELP	III	Coburn 25	1151	17	To for Federal messaging on health promotion and disease prevention
HELP	I	Coburn 280	366	10	To Preserve and Protect Patient's Rights.
HELP	VI	Coburn 293			To ensure that scientific data used by the Federal Government is publicly available for the general betterment of scientific research.
HELP	I	Coburn 307	150	6	To allow for independent insurance agents
HELP	VI	Coburn 312	1864	4	To clarify the definition of interchangeability.
HELP	I	Coburn 315	196	20	Ensure taxpayer dollars do not fund waste, fraud, or other abuse in the Community Health Insurance Plan.
HELP	I - CLASS	Coburn 4	1973	2	Merged bill also includes a Coburn 4, an amendment to ensure that no federal money will be used to fund CLASS
HELP	II	Enzi 11	1660	24	To provide special safeguards for comparative effectiveness research on rare diseases.

HELP and SFC Republican Amendments in the PPACA

HELP	II	Enzi 12	1670	22	To require that experience regarding the actual practice of medicine be among the "diverse and broad range of perspectives" represented on the comparative effectiveness research Advisory Council.
HELP	II	Enzi 15	1659 (conceptual)	25 (conceptual)	To allow expert advisory panels comprising doctors and other clinical experts with relevant specialized experience to advise the government how to conduct comparative effectiveness research studies.
HELP	I - CLASS	Enzi 16	1958	15	To increase the period in which premium payments are required for purposes of eligibility for CLASS benefits.
HELP	I - CLASS	Enzi 17	1931	8	To increase the number of benefit plan as alternatives for consideration for designation by the Secretary.
HELP	I - CLASS	Enzi 18	1933	22	To require health care practitioner certification of functional limitation for the benefit trigger.
HELP	I - CLASS	Enzi 20	1936	17	To strike the Secretarial response to the public comment on the designation of benefit plan.
HELP	I - CLASS	Enzi 21	1937	13	To require the Secretary to consider the Inspector General's annual report on waste, fraud, and abuse related to the program in setting the premium amount.
HELP	I	Enzi 210	186	9	To prohibit the community health insurance option from limiting access to end of life care.
HELP	I - CLASS	Enzi 22	1937	13	To require the Secretary to consider the Inspector General's annual report on waste, fraud, and abuse related to the program in setting the premium amount.
HELP	I	Enzi 241	185	22	To ensure that an individual enrolled in the community health insurance option has access to all services.
HELP	I	Enzi 250	30	8	To require the GAO to conduct a study and report on the quality and cost of health care.
HELP	I - CLASS	Enzi 26	1945	7	To require coordination with the Secretary of the Treasury with respect to payroll deductions.
HELP	I - CLASS	Enzi 27	640	15	To provide for the development of regulations concerning the process for eligibility determinations.
HELP	I	Enzi 272	105	18	To prevent denial of care based on patient age, disability, medical dependency or quality of life
HELP	I	Enzi 274	143	19	To protect pro-patient plans and prevent rationing

HELP and SFC Republican Amendments in the PPACA

HELP	I	Enzi 278	105	18	To prohibit rationing on the basis of patient age, disability, medical dependency or quality of life
HELP	I - CLASS	Enzi 28	1950-51	22	To clarify that advocacy services and advise and assistance counseling services are included as administrative expenses.
HELP	I	Enzi 285	105	9	To prohibit the Secretary of Health and Human Services from limiting access to end of life care
HELP	VI	Enzi 295	1859	12	To set forth the Sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.
HELP	I	Enzi 296	29; 163; 1509	9; 22; 14	To make technical amendments.
HELP	VI	Enzi 297	1859	24	To amend the Public Health Service Act to establish a pathway for the licensure of biosimilar biological products, to promote innovation in the life sciences.
HELP	I - CLASS	Enzi 31	1969	11	To clarify provisions relating to reports on amounts in the Independence Fund.
HELP	I - CLASS	Enzi 32	n/a		To require an option with respect to burdens on the disability determinations of the Social Security Administration.
HELP	I - CLASS	Enzi 33	1967	18	To clarify provisions relating to the soundness of the Independence Fund.
HELP	I - CLASS	Enzi 35	966	7	To provide for an Inspector General's report.
HELP	I - CLASS	Enzi 36	1946	19	To require coordination with the Secretary of the Treasury.
HELP	I - CLASS	Enzi 37	277;810	4;3,8	To require coordination with the Commissioner of Social Security.
HELP	III	Enzi 44	1248	11	To ensure that data is collected on underserved rural populations.
HELP	III	Enzi 45	1248	20	To require that data collection requirements are not effective without a direct appropriation for that purpose.
HELP	III	Enzi 50	1254	24	To ensure that the Secretary conducts workplace wellness evaluations in publicly funded programs before evaluating privately funded programs.
HELP	III	Enzi 51	1255	9	To ensure that information under the workplace wellness provisions are not used to establish Federal requirements.
HELP	III	Enzi 62	1139	1	To modify provisions relating to the national prevention, health promotion, and public health strategy.
HELP	III	Enzi 69	1146	5	To provide that all members of the Preventive Services Task Force are independent.
HELP	III	Enzi 81	1166	19	To strike the definition of community under the school-based health clinic program.

HELP and SFC Republican Amendments in the PPACA

HELP	III	Enzi 82	1159	3	To strike the authority for optional services under the school-based health clinic program.
HELP	III	Enzi 85	1167	16	To clarify that certain oral health activities are subect to appropriations.
HELP	III	Enzi 89	1209	13	To prohibit the use of funds to create video games or other similar tools that lead to higher rates of obesity under the community transformation grant programs.
HELP	III	Enzi 92	1207	21	To clarify provisions relating to community measures under the community transformation grant program.
HELP	II	Enzi 96	1658	10	To require comparative effectiveness research to assess whether treatments benefitting the "average" patient might nevertheless benefit many individuals
HELP	I	Gregg 213	198	13	To require new Federal health entitlement programs to be fiscally solvent.
HELP	I	Gregg 224	Conceptually	Conceptually	To protect taxpayer funds.
HELP	I - CLASS	Gregg 6	1931	18	To protect the long-term fiscal health of the United States
HELP	I - CLASS	Gregg 7	1972	13	To ensure honest budgeting by requiring CLASS Act payments, reciepits, and deficits are reflected in the Budget.
HELP	II	Gregg 9	1111	4	To modify provisions relating to distribution of information to the public.
HELP	III	Hatch 10	1257	14	To promote research and treatment of pain care
HELP	III	Hatch 14	1172	23	To define tooth-level surveillance for purposes of oral healthcare surveillance activities
HELP	III	Hatch 17	1237	9	To utilize community health centers to test several approaches to improve wellness and promote the adoption of healthy lifestyles among several at-risk populations
HELP	III	Hatch 19	1265	11	To ensure that better methodologies are developed to measure prevention and wellness programs
HELP	VI	Hatch 209	1924	15	To authorize a GAO study on the 340B program once the Affordable Health Choices Act is implemented.
HELP	IV	Hatch 22	1355	1	To make technical corrections and improve the bill
HELP	I	Hatch 223	151	19	To modify provisions relating to navigators
HELP	IV	Hatch 23	1302	6	To make technical corrections to improve the bill

HELP and SFC Republican Amendments in the PPACA

HELP	IV	Hatch 24	1295	10	To ensure that the language in the Affordable Health Choices Act is consistent with professional terminology
HELP	III	Hatch 25	1225	21	To ensure that there is no decrease in children's access to immunizations
HELP	II	Hatch 27	1069	3	To ensure that community health teams include doctors of chiropractic
HELP	II	Hatch 9	1133	7	To ensure that the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (PL 109-18) has minimum core proficiency standards for patient navigators
HELP	III	McCain 2	1265	22	To determine whether existing Federal Government sponsored health and wellness initiatives are effective in achieving their stated goals
HELP	I	McCain 205	Conceptually in Section 1252	Conceptually in Section 1252	To establish certain policies for small group health plans.
HELP	III	Murkowski 13	1159	8	Strike lines 4-5 on page 368 and replace with "residents of an area designated medically underserved areas or health professional shortage areas"
HELP	III	Murkowski 14	1163	10	Strike lines 9-12 on page 372 and replace language
HELP	III	Murkowski 20	1224	15	Add language to page 397, line 16 "(I) and immunization information systems to allow all states to have electronic databases for immunization records"
HELP	I	Murkowski 202	80	23	To allow insurers to adjust premium rates for tobacco use.
HELP	IV	Murkowski 23	1274	7	Add definition to page 429
HELP	IV	Murkowski 26	1280	1	Add language to page 433, line 8: "and frontier"
HELP	IV	Murkowski 28	1311	5	Add language to page 463 "(c)(1)(A)…"
HELP	II	Murkowski 3	719	9	Add language to page 243, line 10 "Federal Indian Health Service programs and tribally-operated health programs."
HELP	IV	Murkowski 32	1421	14	Add language to page 558, line 16: "and community health workers."
HELP	III	Murkowski 34	1168	5	Add language to page 376, line 22 after the word "disabilities"; and American Indian, Alaskan Native, and Native Hawaiian
HELP	III	Murkowski 35	1168	5	Add language to page 376, line 22 after the word "disabilities"; and American Indian, Alaskan Native, and Native Hawaiian
HELP	II	Murkowski 38	1091	21	Add language to page 281, line 21 after the word "and"; "expenses associated with physician services."

HELP and SFC Republican Amendments in the PPACA

HELP	II	Murkowski 4	1063	23	Add language to page 255, line 15 "and Federal Indian Health Service programs and tribally-operated health programs."
HELP	IV	Murkowski 40	1357	2	Add language after line 7 on page 510
HELP	IV	Murkowski 44	1316	22	Strike lines 12-13 of page 470; "rate of 2 percent less than the.."
HELP	IV	Murkowski 47	1318	18	Line 12 replace "cost-of-living" with "cost of attendance"
HELP	IV	Murkowski 48	1322	22	"(1)" and place it at (2)(c)
HELP	II	Murkowski 5	1068	11	Add language to page 259, line 22 "or Tribe or tribal organization as defined under the Indian Self-Determination and Education Assistance Act."
HELP	IV	Murkowski 51	1325	13	Add Section (4) "must not have received loan forgiveness through public service loan forgiveness under the Higher Education Act."
HELP	IV	Murkowski 53	1327	16	Strike "other reasonable education expenses"
HELP	II	Murkowski 6	1069	5	Add language to page 260, line 12 "and physicians' assistants"
HELP	II	Murkowski 60	1063	17	Add "Indian health organization" before "quality improvement organization"
HELP	II	Murkowski 61	1082	15	Add "and an Indian tribe or parnership of 1 or more Indian tribes."
HELP	III	Murkowski 65	1246	1	Revise language on line 1
HELP	IV	Murkowski 67	1291	17	Line 8 after "State and local health departments," add "the Indian tribes,"
HELP	III	Murkowski 7	1136	21	Add language to page 348, line 24 "and an Indian tribe and tribal organization"
HELP	III	Murkowski 70	1235	5	Add language to line 10 on page 406 and t line 11 on page 407
HELP	IV	Murkowski 71	1356	8	On page 509, line 20 add "dental health aides"
HELP	IV	Murkowski 72	1356	21	Add language to line 6
HELP	IV	Murkowski 73	1358	18	Add language to page 501, line 10
HELP	III	Murkowski 74	1168	5	Add language to page 376, line 22
HELP	III	Murkowski 75	1169	8	Add language to page 377, line 23
HELP	III	Murkowski 76	1171	1	Add language to page 379, line 13
HELP	I	Roberts 210	105	18	To protect patients by preventing the rationing of health care
HELP	I	Roberts 211	105	18	To protect patients by preventing the rationing of health care
SFC	II	Baucus Amdt. To Hatch C10	604	3	To establish Side-by-side provision to restore $50 million in federal funding to Personal Responsibility Education for Adulthood Training

HELP and SFC Republican Amendments in the PPACA

SFC	III	Baucus Amdt. To Hatch D7	733	11	To grant the Secretary and Chief Actuary of CMS the authority to terminate implementation of Medicare reforms if proven to reduce benefits
SFC	IX	Bunning F4 (as modified)	2033	18	To require a study of how the provisions in the bill will affect the cost of medical care provided to veterans
SFC	I	Cornyn C14	172	12	To strike the political appointment process for the Co-op Advisory Board
SFC	I	Cornyn C15	171	1	Restriction of Federal fund use by the CO-Ops for propoganda
SFC	I	Cornyn C16	171	4	Restriction of Federal fund use by the CO-Ops for marketing
SFC	I	Cornyn C17	176	1	To require that the CO-Ops must meet state solvency standards
SFC	I	Cornyn C18	176	13	To specify that before CO-Ops can operate, the state must have implemented all the insurance reforms required by AHFA
SFC	I	Cornyn C20	176	1	To clarify that CO-Ops must comply with the same state laws as private health insurers
SFC	I	Cornyn C5	157	8	Clarification that existing minimum creditable coverage is exempt from penalty
SFC	III	Ensign D6	739	18	Requires Medicare savings to stay in Medicare
SFC	I	Ensign/Carper C8	87	14	Healthy Behaviors Amendment- To allow a premium discount rate of 30% of the cost of employee-only coverage (with the opportunity to increase to 50%
SFC	I	Enzi C3 (as modified)	356	23	To require a study of how the provisions in the bill will affect employer wages
SFC	I	Grassley C2	177	7	Prohibiting Group Purchasing Councils from Setting Payment Rates
SFC	VI	Grassley D4	1670	7	Would eliminate requirement that Cabinet secretaries and other high ranking officials be appointed to board of PCOR
SFC	I	Grassley/ Bunning C3	156	4	To Require Members of Congress/Congressional Staff to Purchase Healthcare through the Exchange
SFC	III	Grassley/ Hatch D2	797	19	To assure Medicare physician payment equity (Modification: Change "1/2" to "3/4" the difference between the relative costs of employee wages and rents and the national average for the year 2010)
SFC	II	Grassley/ Snowe C11 (incorporates Snowe C5)	407	1	To allow states to scale back coverage to 133%FPL by striking maintenance of effort provision

HELP and SFC Republican Amendments in the PPACA

SFC	II	Hatch C10	618	13	Restores $50 million in federal funding to Abstinence Only-Until-Marriage programs
SFC	I	Hatch C12	364	21	To prohibit Federal funds from being used to pay for assisted suicide and offer conscience protections to providers
SFC	I	Hatch C9	176	1	To Ensure a level-playing field for fair competition
SFC	III	Hatch D7	903	16	Medicare Advantage Benefit Protection
SFC	I	Schumer C6 (and Snowe F4)	326	18	Lower the responsibility penalty and index up to $750 in 2016
SFC	IX	Schumer F1 (Snowe F3, Roberts F3, Enzi F1)	1999	1	To establish a $2500 limit on salary reductions by an employee for a taxable year for purposes of coverage under a health FSA under a cafeteria plan
SFC	I	Schumer/ Snowe C3	332	9	To change the affordability level to no greater than 7% of a beneficiary's income level (modification: changed to 8% in the merged bill)
SFC	I	Snowe C10	159	9	To allow small businesses that grow beyond the upper employee limit in the SHOP exchange to continue to purchase in the SHOP exchange
SFC	I	Snowe C6 (Modified)	109	16	To require small employers to provide a plan with a deductible that does not exceed $2000 for individuals and $4000 for families, unless offering contributions which offset any icnrease in deductible above these limits
SFC	I	Snowe C9	149	24	To allow Small Business Development Centers to receive grants to assist in navigation of the system
SFC	II	Snowe D1	547	1	Establishment of a Medicaid Emergency Psychiatric Demonstration Project
SFC	I	Snowe F5	115	17	To allow individuals who would otherwise qualify for the exemption from the individual assessment (due to low income) in the Exchange could purchase the "young invincibles" policy
SFC	I	Snowe/ Lincoln C3 (Snowe C8)	130	11	Establishment of Small-business Health Options Program (SHOP) in the Exchange
SFC	I	Wyden C8 (Grassley C15 & C16)	212	12	A State may apply to the Secretary for the waiver of all or any requirements of the Exchange beginning 2017

Mr. DODD. Mr. President, specific pages in this bill and the language of these amendments or a synopsis of the language is included. These were not just technical amendments. Let me mention some that were included.

Our colleague from North Carolina, Mr. BURR, offered an amendment that subjects the public option to the same laws and requirements as private plans. This discussion that they were not involved in the public option—here are amendments offered by Republicans accepted in the committee dealing with the public option. Did we take all of them? Of course not. Of the 287 amendments, 161 of them, as you will now read, are reflected in these efforts.

Follow-on biologics: A bipartisan, Enzi-Hatch-Hagan—HAGAN, a Democrat, and HATCH and ENZI, Republicans—amendment establishes the pathway for biosimilar biological products. This Republican amendment is reflected in the bill on page 1859.

Long-term care: Senator GREGG ensured that the new voluntary program to approve long-term care options would remain solvent for 75 years—the CLASS Act—reflected on page 1931 of the bill.

Prevention—again, a bipartisan amendment offered by Senator GREGG and Senator HARKIN that expands and strengthens the incentives available for participation in workplace wellness programs, reflected in the bill on page 80.

The Murkowski of Alaska amendment will allow insurance companies to offer discounts for those who do not smoke. This is a Republican amendment reflected on page 80 of the bill.

Coverage: Several amendments were offered by Senators ENZI, COBURN, ROBERTS, and others to make certain that nothing in the legislation would allow for rationing of care and that no one would be denied care based on age, disability, medical dependency, or quality of life. That is reflected as well on page 105 of the bill.

My colleague from Wyoming, the ranking member of the committee, had 41 amendments that were included in the bill. For instance, in Title I, Enzi amendment No. 241 appears on page 185 of the marked-up bill. Line 22: to ensure that individuals enrolled in the community health service option have access to all services. Senator ENZI's amendment is included in the bill. He offered amendments on page 272 to prevent denial of care based on patient age, disability, medical dependency, quality of life, and antirationing proposals; follow-on biologics; amendments to protect and ensure that data and prevention programs include rural populations. Again, I will provide a list of the 41 amendments so my colleagues and others can read a synopsis of those amendments—hardly punctuation marks in the bill. We may not agree with every one. We accepted them. I thought they contributed to the bill, made a better bill. I did not decry them; I welcomed them.

So the suggestion that this somehow has been jammed down the throats of people, with secret meetings going on—I don't think people ought to engage in that. You can vote against the bill if you want, but don't suggest to me this process denied people a chance to be heard, to be involved, to be engaged. I went out of way my in the markup of that bill to stay for as many hours as people wanted to, for as long as they wanted to, to offer as many amendments as they wanted to. Staff worked all during the weekends of that process to go through these amendments. I remember on one occasion, after work over one weekend, I proposed accepting 40 amendments. I offered to accept all 40 of them, and my Republican friends objected to a request to accept their amendments in the committee.

So the notion we marked up titles of this bill without adequate notice of language is false. Titles of the bill had to be scored by CBO. The idea that we would markup our bill without notice of language or CBO scores again is false. The markup dates were postponed by me to allow more time to read language and to ensure that CBO scores were distributed to all Members as well.

As someone who has been around here a number of years, I know when there is a true willingness to have a bipartisan effort and I know when there is one that is not going to happen. Senator Kennedy understood that as well. I have had numerous bipartisan agreements with my colleagues on committees I have served on over the years. It is certainly far better when you can achieve that, I don't deny that at all, but I will not accept the notion that there has been a refusal to accept or willingness to listen to bipartisan ideas as part of this bill.

Again, there is a debate that I know is going on on the other side as to whether to have amendments or not have amendments, whether Rush Limbaugh is controlling the show, or the Republican leader. Those things happen. I understand that. But the fact is, we have a bill here, far from perfect—I will be the first to acknowledge it. It is not a bill I would have written on my own. But we serve in a body of 100 coequals who bring to our debate and discussion various backgrounds, experiences, and viewpoints. It is not an easy task.

Every Congress going back to the 1940s to one degree or another has tried to deal with this issue. Every administration, from Harry Truman through every Republican and Democratic administration since the 1940s, has, to one degree or another, grappled with this issue of health care. To a large extent, everyone has failed or has not tried because it has been so monumental an undertaking that it has been daunting. Certainly, we are seeing that as we grapple with it in our hour of watch. Those of us who are privileged to be here serving with an administration that has made this a priority have been challenged to do what no other Congress and no other administration has been able to achieve over the past 70 years. We are close to achieving a major beginning, and it is a beginning. Anyone who suggests otherwise does not understand the complexity or the largeness of this undertaking—a beginning, to begin to change and bring down costs, increase access, and affordability, as well as the quality of something that ought to be a basic right in the United States of America, and that is health care.

I am excited and optimistic about the possibility of achieving that. It is less than what I wished we could have done, but it is far more than has ever been achieved by others.

The product we have before us, while it is not one that has been endorsed on a bipartisan basis, reflects a lot of good contributions made by all Members. In fact, every single member of the HELP Committee—every single member—offered amendments that were adopted as part of our product—every single one. Substantive amendments were offered as well. I find it somewhat intriguing, that people claim to feel excluded from the public option idea. I had no idea they were interested in one. It is exciting to know they have some ideas on the public option. The reflection that occurred during our debate was they were totally opposed to any public option in this bill. So we adopted one as part of the HELP Committee process, under the leadership of SHERROD BROWN and SHELDON WHITEHOUSE and KAY HAGAN of North Carolina, who sat together and, working with others outside, came up with an option that we thought would appeal on a bipartisan basis. It did not, and we are very much involved in that debate as we speak.

Anyway, I wanted to respond to these earlier suggestions, and I will leave them as suggestions, that somehow this product and process has been totally written on a partisan basis. It is anything but that, and I want the RECORD to reflect that, hence the decision to include the specific amendments, the pages on which they exist in our product, and the substance of the ideas that were contributed by our Republican friends.

Mr. President, I saw my colleague from Montana a moment ago, who may be interested in addressing some of these ideas and thoughts as well that are coming before us. But while I wait for him to come to the floor, let me say that, again, I hear constantly this talk about Medicare and the cutting of Medicare. Let me reflect on how false those allegations are.

Again, what we are trying to do is to reduce the overpayments under the Medicare Advantage Program. That is what has happened here. These private plans—and that is what they are—operating under Medicare Advantage have two options: They can cut benefits or reduce their profits. We have to bring down these costs when you have an average of 14 percent overpayments occurring in the country that are being

borne by 80 percent of Medicare recipients.

We talk about the numbers. I have a number: 96,000 people in the State of Connecticut who utilize the Medicare Advantage plan. I am not opposed to that. I think it is a wonderful option for people. But the fact is 470,000 other people in my State, who are Medicare recipients, are paying $90 extra in order to subsidize the Medicare Advantage plan and they are getting none of the benefits for it. So there is a huge percentage—about 80 percent of the elderly in this country—who are writing a check every year to subsidize private health care plans. These plans are profiting at the expense of people who never get a benefit from it.

What Senator BAUCUS and others have suggested is let's reduce these overpayments. It is up to the plans to decide what they want to do with that. They can decide to cut the benefits or take less profit. These are for-profit plans that are doing this. Maybe they don't want to take less profit. That might be a part of the motivation. But traditional Medicare, the guaranteed benefits under that—a nonprofit operation—are not touched in this bill—not a single guaranteed benefit. For over a week now I have challenged any Member in this body to identify a single guaranteed benefit under Medicare that is affected by this bill. Not one. Eliminating the overpayments under Medicare Advantage are, clearly, because we don't think that 80 percent of the population who qualify for Medicare ought to bear the financial burden of financing a benefit they never get.

None of us are opposed to Medicare Advantage, but we are opposed to the idea that these for-profit companies can play the game by suggesting they don't want to take less profit, they don't want to reduce any benefit, so they want to leave it exactly as it is. You want to know why Medicare is in trouble? That is why. If you want to put it on a solid footing for an additional 5 years, then take the proposal we have in the bill to reduce these overpayments. In the absence of doing that, the very people who are worried about the solvency of Medicare are going to be correct, because Medicare will be in financial jeopardy far earlier if we have these amendments adopted that would jeopardize the traditional Medicare Program.

Clarity is needed on all of this. The fact something is called Medicare Advantage, as I have said repeatedly, doesn't make it Medicare and it is certainly not an advantage. It is only an advantage for those private companies that are benefitting in terms of the profits they make. In fact, studies done by independent analysts say, that these companies have seen a 75 percent growth in profits as a result of this program. They are doing very well financially as a result of this. But they shouldn't be doing necessarily that well at the expense of others who are paying an additional $90, on average per couple of retirees, elderly people, who are contributing that amount every year without receiving a single benefit under Medicare Advantage.

Our simple question is: Why should they be asked to pay that much more? Ninety dollars a year may not sound like that much to a Member of Congress, but if you are a retired elderly person, living on a fixed income, that $90 a year can make a huge difference. It may not be much to a Member of Congress, many of whom, of course, are very wealthy indeed, but it is if you are sitting out there across America writing a check each year for $90 to go into a program you never get a benefit from, which serves 20 percent of the senior population.

I don't blame the 20 percent at all. I understand how they feel. They wish to continue to get those benefits. And they can get them, provided the companies they are getting those benefits from are willing to take less in profits. That is what our bill is designed to do—to provide that choice. Obviously, we can't mandate that from them—although we were promised early on they would be able to reduce the cost of Medicare. That was the original proposal when Medicare Advantage was adopted many years ago—a number of years ago.

Again, it is anything but Medicare and it is anything but an advantage, except for the profit-making companies that have done very well off this program. Our bill here merely restrains the overpayments. I know that may bother these companies. They would like to make more, if they could, and I respect that, from their vantage point. But we should not, as the Senate, sanction and necessarily approve a proposal that allows them to make more money out of the pockets of people on fixed incomes to support a fraction of the population at the expense of the overwhelming majority. Where is the equity in that, when 80 percent of Medicare recipients are writing a check each year to private companies, in effect, to pay for benefits they never get?

I appreciate the support of organizations across the country—AARP and certainly the National Committee to Preserve Social Security and Medicare—and we thank them for their very strong letters. These major organizations, representing 43 million of our elderly in this country, have taken a very strong position against the assaults on this bill regarding the overpayments that are occurring, and we thank them for it. That may not be enough for some people to appreciate, but I believe if they look and listen to what is going on here, they will understand what is at stake. If you are part of the 80 percent of seniors out there who are writing those checks every year and getting none of the benefits, those who oppose our bill want to maintain and probably expand on it in the years ahead. So for you out there who are worried about the cost and solvency of Medicare, our bill is a major step in the direction of reducing those overpayments and providing the options that ought to exist to reduce profits or extend benefits.

Again, I think it is important to remind our colleagues that under this bill, there is $130 billion in budget reductions in the first 10 years. It is the largest single reduction. We listened to our colleagues from North Dakota and New Hampshire talk about deficit reduction. This bill provides $130 billion in deficit reduction in the first 10 years and $650 billion of deficit reduction in the second 10 years.

We are now told by the Congressional Budget Office there are the millions of people today who are paying insurance and watching the costs escalate almost on an hourly basis. Even with zero inflation, we are watching private companies raise the cost of premiums—going up dramatically. There are 32 million people in the individual insurance market, according to the Congressional Budget Office, and they would pay 14 to 20 percent less in premiums for an equivalent plan than under the status quo. That is a huge reduction, potentially, in the years ahead for 32 million of our fellow citizens in the individual market. If you are in the small-group market—there are 25 million people in that, according to the CBO's analysis—you are eligible for tax credits and would pay 8 to 11 percent less in premiums. If you work for a small business and don't qualify for a tax credit, you would see a reduction, potentially, of 2 to 3 percent in premiums. If you are in the large-group market—and there are 134 million of our fellow citizens who are in that market, according to the Congressional Budget Office—again, you could see a reduction.

So in any category, you have a choice here to make—and we do in the coming hours. Do you want to continue the present process? And when people say status quo, it is such a misnomer. The status quo might even be acceptable to people if you could freeze everything. But you can't freeze everything. The status quo allows for a dramatic increase in premiums—dramatic increase. If we don't take steps to deal with rising costs, as we do in this bill, you are looking at premiums going from $12,000 a year for a family of four in this country to $24,000 to $35,000 in the next 7 to 10 years.

If this gets defeated—and, obviously, our Republican friends want this bill defeated—the idea that we are going to jump back into this is a pipe dream. We will end up with dramatically increasing costs to millions of our fellow citizens, which this bill restrains because of the hard work done by the Finance Committee, particularly, that had to work on these issues. So for those who suggest the status quo is okay, it is anything but okay.

In terms of cost reduction overall, as well as premium reduction, which is so important—and I thank my colleague from Indiana, Senator BAYH, who was

the one who insisted CBO give us the analysis of what the impact of this bill would be on premiums—the fact is we see significant reductions of premium costs.

I see my colleague from Montana is now here, but I would give the example that in Connecticut, premiums in the year 2000 for a family of four were about $6,000. In the year 2009, that family of four in Connecticut is now paying around $12,000. So in 9 years, premiums have jumped from $6,000 to $12,000. And those numbers continue to escalate. So for those who say no to this bill, then—if you succeed in these efforts—prepare to answer the question why is it the premiums of those people you claim you are defending around here—if they have insurance—will escalate to the rates we have talked about. That is what is at stake—nothing less than that.

Whether it is so-called Medicare Advantage or cost reduction or premium reduction, this bill, with all of its imperfections, is a major, giant, positive step forward for our country. Again, I thank the members of the Finance Committee and Members of the HELP Committee, both staffs, and others who have worked to include many of the ideas that our friends on the other side wisely and thoughtfully made a part of these efforts.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I want to underline the huge bipartisan effort that this side undertook to put this bill together in many, many ways. I very much appreciate the comments of the Senator from Connecticut on that point.

Let's go back. A year ago, I held an all-day health care summit at the Library of Congress for members of the Finance Committee, Republicans and Democrats. They were all there. We spent a whole day. In addition, I talked to all the groups. I called them up and said: Look, we are all in this together—we Americans—consumer groups, labor, big business, small business, the pharmaceutical industry, hospitals, hospice, all these CEOs. I said: We are all working together to get health care reform passed for our country—for all Americans.

So we kept that process up to keep it—and I don't like that word ''bipartisan.'' It is more accurate to say that everybody was working together. If you don't like something, maybe you will like something else somewhere else.

The PRESIDING OFFICER (Mr. KIRK). The time of the majority has expired.

Mr. BAUCUS. Just as I was getting wound up, Mr. President. I will continue when the majority's half-hour comes around.

Mr. MCCAIN. Mr. President, I ask unanimous consent the Senator from Montana be given 2 additional minutes.

Mr. BAUCUS. I appreciate very much the 2 minutes from the Senator from Arizona. This could take a couple more than 2 minutes, but I very much appreciate the offer. I will just wait.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. I ask unanimous consent to enter into a colloquy with the Senators from Oklahoma, Tennessee, and Tennessee, both of them.

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

Mr. MCCAIN. Mr. President, we are here, obviously, as we are on a daily basis, to discuss the issue of health care reform. But we are in a rather unusual situation this morning because we don't know what we are discussing or debating. We find ourselves in an interesting situation.

After almost a year of consideration of health care reform, with a measure that has been—at least a couple of the outlines of it we know but, frankly, we have had no details except that Medicare is going to be extended, eligibility for Medicare is going to be extended to age 55.

I just would quote: There was a meeting yesterday amongst Senate Democrats. Many Senate Democrats emerged from yesterday's caucus meeting saying they had learned little about the public option agreement and there were many outstanding concerns.

Senator MARY LANDRIEU called the agreement ''a very good idea.'' Senator BLANCHE LINCOLN said, ''More information is needed.'' And Senator BEN NELSON said, ''I just want to know what the costs are.''

So do the rest of us. So do the rest of us. Here we have a proposal after nearly a year that is being assessed by the Congressional Budget Office, and here we are with no knowledge of what that bill is about, with the exception of some bare essentials that have been leaked.

What did this have to do with change? What does this have to do with bipartisanship? What does this have to do with anything?

Frankly, we have an editorial in the Washington Post this morning that calls it ''Medicare Sausage?''

I ask unanimous consent the editorial from the Washington Post be printed in the RECORD.

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

[From the Washington Post]

MEDICARE SAUSAGE?

THE EMERGING BUY-IN PROPOSAL COULD HAVE COSTLY UNINTENDED CONSEQUENCES

The only thing more unsettling than watching legislative sausage being made is watching it being made on the fly. The 11th-hour ''compromise'' on health-care reform and the public option supposedly includes an expansion of Medicare to let people ages 55 to 64 buy into the program. This is an idea dating to at least the Clinton administration, and Senate Finance Committee Chairman Max Baucus (D-Mont.) originally proposed allowing the buy-in as a temporary measure before the new insurance exchanges get underway. However, the last-minute introduction of this idea within the broader context of health reform raises numerous questions—not least of which is whether this proposal is a far more dramatic step toward a single-payer system than lawmakers on either side realize.

The details of how the buy-in would work are still sketchy and still being fleshed out, but the basic notion is that uninsured individuals 55 to 64 who would be eligible to participate in the newly created insurance exchanges could choose instead to purchase coverage through Medicare. In theory, this would not add to Medicare costs because the coverage would have to be paid for—either out of pocket or with the subsidies that would be provided to those at lower income levels to purchase insurance on the exchanges. The notion is that, because Medicare pays lower rates to health-care providers than do private insurers, the coverage would tend to cost less than a private plan. The complication is understanding what effect the buy-in option would have on the new insurance exchanges and, more important, on the larger health-care system.

Currently, Medicare benefits are less generous in significant ways than the plans to be offered on the exchanges. For instance, there is no cap on out-of-pocket expenses. So would near-seniors who buy in to Medicare get Medicare-level benefits? If so, who would tend to purchase that coverage? Sicker near-seniors might be better off purchasing private insurance on the an exchange. But the educated guessing—and that's a generous description—is that sicker near-seniors might tend to place more trust in a government-run program; they might assume, with good reason, that the government will be more accommodating in approving treatments, and they might flock to Medicare. That would raise premium costs and, correspondingly, the pressure to dip into federal funds for extra help.

In addition, the insurance exchanges proposal is being increasingly sliced and diced in ways that could narrow its effectiveness. Remember, the overall concept is to group together enough people to spread the risk and obtain better rates. But so-called ''young invincibles''—the under-30 crowd—would already be allowed to opt out of the regular exchange plans and purchase high-deductible catastrophic coverage. Those with income under 133 percent of the poverty level would be covered by Medicaid. The exchanges risk becoming less effective the more they are Balkanized this way.

Presumably, the expanded Medicare program would pay Medicare rates to providers, raising the question of the spillover effects on a health-care system already stressed by a dramatic expansion of Medicaid. Will providers cut costs—or will they shift them to private insurers, driving up premiums? Will they stop taking Medicare patients or go to Congress demanding higher rates? Once 55-year-olds are in, they are not likely to be kicked out, and the pressure will be on to expand the program to make more people eligible. The irony of this late-breaking Medicare proposal is that it could be a bigger step toward a single-payer system than the milquetoast public option plans rejected by Senate moderates as too disruptive of the private market.

Mr. MCCAIN. ''The emerging buy-in proposal could have costly unintended consequences.''

But we don't know what it is. But we know that never before in this entire year—I ask my colleagues—have we seen a proposal that would change eligibility for Medicare down to age 55, never before.

The majority leader came to the floor this morning and said if we accept

an omnibus, a multitrillion-dollar bill by unanimous consent—by the way, the Omnibus appropriations bill is six bills totaling $450 billion, 1,351 pages long, with 4,752 earmarks totaling $3.7 billion. And, by the way, spending on domestic programs is increased by 14 percent except for veterans, which is increased by only 5 percent.

The majority leader wants us to go out for the weekend, after keeping us in all last weekend. Here we have an unspecified proposal—none of us know the details or the cost—so I am supposed to go home to Arizona this weekend and say: My friends, we have been working on health care reform for a year. And guess what. I can tell you nothing.

We need to stay in, we need to know what the proposals are, we need to have votes on it, and we need to tell the American people what is going on behind closed doors.

Mr. MCCONNELL. Will the Senator from Arizona yield?

Mr. MCCAIN. Gladly.

Mr. MCCONNELL. I recall our good friend, the majority leader, telling us on November 30 that we would be here the next two weekends. Then I recall our friend, the majority leader, saying Monday of this week we would be here this weekend.

My assumption was we were here to deal with this important issue that the majority has been indicating to everyone is so important, that we must stay here and do it. We are prepared to be here.

Mr. MCCAIN. And vote.

Mr. MCCONNELL. And vote. In fact, we have been trying to vote for a couple of days now, and it has been difficult to vote.

Mr. MCCAIN. If we are not going to have a vote, maybe we ought to have a vote to table the pending amendments, at least to have the Senate on record.

Could I finally say, I know New Orleans is very nice this time of year, but perhaps we ought to stay here and get this job done?

Mr. ALEXANDER. I think it is important to reflect on the season we have here. A couple of nights ago, the Senator from Arizona gave an impressive speech in front of the Capitol for the lighting of the Christmas tree. This is the Christmas season coming up, 2 weeks from tomorrow, a very important season. The majority leader said it is very important for us to stay through Christmas if necessary to debate this bill. We said: All right, that is what we will do. We will stay to New Year's Day. We will stay to Valentine's Day because this is indeed a historic bill and we don't want to make a historic mistake because it affects our children, our grandchildren, 17 percent of the economy, all 300 million Americans.

None of us have ever seen our constituents more involved in an issue than in this issue. So we are here ready to go to work.

I am wondering, as I listen to the Senator from Arizona, not only do we not know what this bill is that we are supposed to enact by 2 weeks from today, our friends on the other side don't know what it is. They cannot tell each other what it is.

They came out of—they had sort of a rally yesterday. One of the Senators described it as sort of a ''go team, go'' rally, but they did not know what they were going to. All we have heard they are going to—and I imagine the Senator from Oklahoma, who is a physician, who has delivered many babies, seen many patients, still continues to do it, would have some comment on this—all we have heard is they may try to expand Medicare.

We heard yesterday from the executive director of the Mayo Clinic Health Policy Center, I ask unanimous consent to have his letter printed in the RECORD.

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

MEDICARE EXPANSION WON'T GET US THERE

PROPOSAL WOULD NOT INCREASE ACCESS TO HEALTH CARE SERVICES OR CONTROL COSTS

The current Medicare payment system is financially unsustainable. Any plan to expand Medicare, which is the government's largest public plan, beyond its current scope does not solve the nation's health care crisis, but compounds it. We need to fix Medicare by moving it to a system that pays for value—quality health outcomes that are affordable over time—and ensure its success, before bringing more people into a broken system.

Expanding this system to persons 55 to 64 years old would ultimately hurt patients by accelerating the financial ruin of hospitals and doctors across the country. A majority of Medicare providers currently suffer great financial loss under the program. Mayo Clinic alone lost $840 million last year under Medicare. As a result of these types of losses, a growing number of providers have begun to limit the number of Medicare patients in their practices. Despite these provider losses, Medicare has not curbed overall spending, especially after adjusting for benefits covered and the cost shift from Medicare to private insurance. This is clearly an unsustainable model, and one that would be disastrous for our nation's hospitals, doctors and eventually our patients if expanded to even more beneficiaries.

It's also clear that an expansion of the price-controlled Medicare payment system will not control overall Medicare spending or curb costs. The Commonwealth Fund has reported this result for Medicare overall by looking at two time periods—one four-year period where Medicare physician fees increased and one four-year period where Medicare physician fees decreased. Overall cost per beneficiary increased at the same rate during each time period. This scenario follows the typical pattern for price controls—reduced access, compromised quality and increasing costs anyway. We need to address these problems—not perpetuate them—through health reform legislation.

We believe insurance coverage can be achieved without creating or expanding a government-run, price-controlled, Medicare-like insurance model.

Mayo Clinic supports the proposed insurance exchange model based on the Office of Personnel Management's Federal Employees Health Benefit Plan (FEHBP). This system will improve access to insurance, make reforms to the current insurance system that eliminate pre-existing condition exclusions, and create an individual mandate where individuals can purchase private insurance in various ways: through employers; on the individual market; through co-operatives; or through an exchange model like the FEHBP.

We also believe that the government should help people pay for insurance premiums through sliding scale subsidies as needed.

JEFFREY O. KORSMO,
Executive Director,
Mayo Clinic Health Policy Center.

Mr. ALEXANDER. I will just read one sentence from it:

Expanding the current Medicaid system to persons 55 to 64 years old would ultimately hurt patients by accelerating the financial ruin of hospitals and doctors across this country.

I am very puzzled why ideas like this are being cooked up behind closed doors 2 weeks before Christmas, and we do not know what they are, they don't know what they are, and the suggestion is we not vote today and we go home this weekend.

Mr. MCCAIN. Not only are there questions—not only is there opposition from the Mayo Clinic but the American Hospital Association and the AMA. They have all come up steadfastly against this.

Could I ask my colleague from Oklahoma—and I quote from this editorial. Here we are supposedly going out for the weekend and the editorial from the Washington Post says:

Presumably, the expanded Medicare program would pay Medicare rates to providers raising the question of the spillover effects on a health-care system already stressed by a dramatic expansion of Medicaid. Will providers cut costs—or will they shift them to private insurers, driving up premiums? Will they stop taking Medicare patients or go to Congress demanding higher rates? Once 55-year-olds are in, they are not likely to be kicked out and the pressure will be on to expand the program to make more people eligible. The irony of this late-breaking Medicare proposal is that it could be a bigger step toward a single-payer system than the milquetoast public option plans rejected by Senate moderates as too disruptive of the private market.

Mr. COBURN. I will answer my colleague as somebody who has practiced medicine for 25 years: MedPAC, last year, said 29 percent of Medicare beneficiaries it surveyed were looking for a primary care doctor and had great difficulty in finding somebody to treat them.

That is now. In the State of Texas, 58 percent of the State's doctors took new Medicare patients, but only 38 percent of the State's primary care doctors took new Medicare patients.

I would make the case to you that if you delay care, that is denied care. It is exacerbated in our older population because an older person with a medical need is much more susceptible to the complications that can come from that initial problem. So if you delay the care, you are denying the care and you are actually increasing the cost.

There are 15 million people in this population. I have no idea if their plans include all of them. But if you add 15

million new people to Medicare, what you are going to have is 50 percent of them are not going to find a primary care physician to care for them because the rate of reimbursement does not cover the cost of care.

I think the editorial you quote is exactly right.

I would also note, if I may, that President Obama loves the Mayo Clinic, and rightly so. I had a brain tumor removed the summer before last by the Mayo Clinic. I am standing here on the Senate floor because of their expertise.

Mr. MCCAIN. There are many who believe the Senator from Oklahoma could not have a heart attack.

Mr. COBURN. I will ignore that comment.

The fact is, what Mayo says is we have to figure out how we create incentives in terms of how do we get people cared for at a lower cost. Medicare is not the way to do it.

As a matter of fact, I heard our colleagues talk. We have had eight votes since last Saturday. We are ready to vote. This is a 2,074-page bill. I have 15 amendments in the queue. I want to vote on them.

They don't want to vote because they don't want the American people to hear all the bad things about what is going to happen to their health care if this bill passes. If we do Medicare, what is going to happen is Medicare costs are going to skyrocket, but access is going to go down.

Mr. MCCAIN. Apparently, I would ask my colleague from Tennessee, we do not know what we would be voting on because there has been a whole rewrite of this health care reform here after a year. We do not even know what the provisions of that bill are except what has been leaked. Apparently, my colleagues on the other side of the aisle, with the exception of the majority leader, don't know what it is either.

Mr. COBURN. If the Senator will yield, there are some things we could vote on. President Obama outlined some very specific things that ought to be in this bill. We ought to vote to put them in the bill.

What he said he wanted and what this bill presents are two different things. We ought to vote on making sure everybody has access. We ought to vote on making sure we are under the same plan as everybody else we are going to put into any new expanded health care coverage. We ought to vote in making sure everybody is treated fairly in this country. We ought to vote on your prescription drug reimportation. We ought to vote. But what we are doing is we are getting a slowdown.

We heard we are obstructing the bill. We are not obstructing the bill. Any other bill that comes before this body that had 2,000 pages in it we would allot 8 weeks, 10 weeks to debate.

As our colleague from Maine knows, there is not a more complicated subject that will affect more people that this body has ever taken up. We are trying to squeeze that into 3½ weeks, and the last 2 weeks we don't know what is in the bill.

Time out.

Mr. CORKER. I would like to thank the Senator from Arizona for his great leadership on this issue. I agree with all here. I would like to continue to discuss this, ''colloquize,'' if you will, and vote. That is what we need to do all weekend is talk about this issue and vote.

There are numbers of amendments. But the thing that is interesting to me, I say to the Senator from Arizona—he has been one of the great champions in this country as it relates to how we live within our means. He has pointed out waste in government. He has pointed out overspending.

What has happened during this Christmas season is, for our friends on the other side of the aisle Medicare has become the gift that just keeps on giving.

I know the Senator talked about, during his campaign—and all of us have—that we need to get Medicare to a point where it is solvent, where seniors actually have the ability to use the benefits later on that now are in place. We have all talked about the need to make it solvent.

What does the base of this bill do? It takes $464 billion out of Medicare to create a whole new entitlement. It doesn't even deal with the doc fix, as we have said many times.

The reason, by the way, we do not know what this says is the leadership on the other side—this is another one of those yellow post-its. They are throwing it up on the wall just to see if it works. They are not telling us what the game plan is because they don't yet know whether it works. What they are hoping to do is to solve a major problem they have within their caucus, again, by taking from Medicare.

If you think about the fact that the Mayo Clinic, which is the model for all of us, would not even take new Medicare patients, and yet our friends on the other side of the aisle are trying to throw a whole new decade of seniors into the plan, what that means is less and less seniors are going to have access to care. That is what this means.

The other side of the aisle, I will have to say, based on history, I am surprised, but they continue, through their policies, to throw seniors under the bus.

I do not understand what has happened. This must be about a political victory and not about health care reform. What we would do is more firmly put in place, again, bad policy. The problem with Medicare today is physicians and providers are paid fees to do more work. So now what we would be doing, instead of health care reform, which is what Senator COBURN and all of us have talked about for some time, we are putting in place, in cement, something that works poorly, that the Mayo Clinic said is damaging to them and their patients, we would be putting it in place for even more people.

I thank the Senator for his leadership. I hope to be with him all weekend discussing amendments that are important and voting on those amendments. I can't imagine a better place for all of us to be.

Mr. MCCAIN. I thank the Senator. May I ask the Republican leader, again, to be very clear that it is his view and that of all Republican Members that we will stay in for as long as it takes to get this issue resolved and we are prepared to vote throughout the entire weekend. If the majority leader moves to the Omnibus appropriations bills, we will have a conference report, and we will certainly have discussion about a bill that has 4,752 earmarks totaling $3.7 billion. But we should not get off this, should we?

Mr. MCCONNELL. My friend is entirely correct. I can only quote the majority leader himself who said we were going to be here this weekend. We expect to be here this weekend. If he tries to leave, we will have a vote to adjourn, and I am confident every Republican will vote against adjourning. This either is or it isn't as important as the majority says it is. If it is that important, we need to be here. More importantly than being here, equally important to being here is to vote. We tried to get a vote all day yesterday on a motion by Senator CRAPO. What we heard from the other side is: We are working on a side-by-side. That is kind of parliamentary inside talk for delay. We are ready to vote. As several of our colleagues have suggested, we keep hearing about these new iterations of this bill. It reminds me of the end of a football game, trying to throw a ''Hail Mary'' pass, just somehow, some way find a way to pass this bill. I think it important to remember what happens to most Hail Marys. They fall to the ground incomplete. You get the impression they are far less interested in the substance of the bill than just passing something.

When the President came up here last Sunday, he said: Make history. Make history? The American people are not asking us to make history by passing this bill. They don't believe it is about the President. They believe it is about the substance. We are out here prepared to talk about the substance of this measure, offer amendments, and we fully intend to do it for as long as it takes. As the Senator has suggested, if the majority leader pivots to a conference report, which he is able to do under our process, we will spend all the time it takes to deal with the conference report.

Mr. MCCAIN. May I point out, again, as the Senator from Maine, Ms. SNOWE, pointed out—and it was highlighted in the Wall Street Journal—no major reform in the modern history of this Senate has been enacted without bipartisan support, a reason for us to go back to the drawing board.

I know the Senator from Texas has been heavily involved in the issue of

hospitalization and the American Hospital Association's reaction to what appears to be an expansion of Medicare.

Mrs. HUTCHISON. I thank the Senator from Arizona. I am pleased our leader is standing strong to say nothing should take precedence over our handling of this bill and making sure it is done right. That is what the Republicans are trying to do, to make sure this is done right. We talked about the Medicare expansion that is in the purported bill that we have not seen yet but that Democrats appear to be putting forward. We have also been spending the week talking about $½ trillion in cuts to Medicare. Now we are talking about possibly expanding Medicare at the same time we are cutting $½ trillion out of the care Medicare patients would get.

I have an amendment. It would stop the $135 billion in cuts in the underlying bill to hospitals, cutting hospital reimbursements for Medicare patients. That is my amendment. Now we are talking about possibly expanding Medicare. The American Hospital Association put out an alarm, an action alert. It says:

> Medicare pays hospitals 91 cents for every dollar of care provided. Medicaid pays just 88 cents for each dollar of care provided.

Medicaid, which may also be expanded, and the cuts in Medicare, which we are talking about possibly expanding, would go forward. Which means what? The hospital association knows what. ''What'' is rural hospitals that care for Medicare patients are going to go under. What kind of services can be provided if there is no hospital in the whole county that can provide care to these senior citizens? I ask the Senator from Arizona, who has been such a leader on this, we are going to cut $135 billion out of Medicare coverage for hospitals. We are going to now talk about expanding the coverage of more Medicare patients, which will mean we will cut more from the hospitals than is even envisioned in the underlying bill. Help me understand this, Senator. How would you suggest that passes the commonsense test?

Mr. MCCAIN. May I say, having stood fifth from the bottom of my class at the Naval Academy, I cannot explain it. But perhaps before I turn to the Senator from South Dakota, maybe we could get a response from Dr. COBURN to that question.

Mr. COBURN. They are going to cut care. We are going to have more complications and worse outcomes. That is what is going to happen. Rather than changing the payment formula, which is what we should do, by rewarding quality and rewarding outcome, rather than rewarding flipping a switch, that is what needs to happen. We are going to take the same antiquated system, we are going to cut $465 billion from it, and then we are going to add, as my colleague from Tennessee said, it is 34 million people, if they include everybody from 55 to 64 in the same program.

Mrs. HUTCHISON. Is the Senator saying that whether you were at the top of your class, such as the Senator from Oklahoma or the Senator from Tennessee or the Senator from South Dakota, or the bottom of your class, as the Senator from Arizona has admitted he held down the fort, regardless of where you are on the quotient of where you stood in your class, you know what the bottom line is.

Mr. COBURN. Care is going to be impacted. Here is a survey of 90,000 physicians. That is more than the active practicing physicians of the AMA. More than 8 in 10 physicians surveyed think payment reform is best to improve the system for all Americans. Only 5 percent of the physicians surveyed rated the current government health care program as effective, 5 percent.

Mr. MCCAIN. I yield to the Senator from South Dakota.

Mr. THUNE. I ask my colleague from Arizona if this is what happens when you end up with one-party rule, one party trying to go this on their own. This seems to be a model of dysfunction in how to come up with a solution to one of the major problems facing the American people, dysfunctional by Washington's twisted standards. They seem to be desperately throwing things at the wall, hoping something will stick. Surely, there has to be a better suggestion coming from the other side than to expand a program that is destined to be bankrupt in the year 2017. It is the equivalent of a ship that is sinking. It is similar to the Titanic. You will put more people on the deck of a sinking ship. Clearly, the overall objective, at least among some, and I think some have been very transparent about it—someone quoted earlier today the Congressman from New York in the other body who said this is the mother of all public options. He went on to say:

> Never mind the camel's nose. We have his head and neck in the tent on the way to a single-payer system.

Obviously, there are people here who want to see a single-payer system, who want to see government-run health care. We don't happen to believe that is the best solution for America's health care system, but the amazing thing about this proposal is, it takes a program that is destined to be bankrupt in a few short years, cuts $1 trillion out of it over 10 years, when fully implemented, and then adds millions of new people into that program. It is hard to come up with any rational explanation for what is going on here, other than that they are left with, in desperation, trying to throw something at the wall, hoping it will stick. Is this typically what happens around here when one party tries to go on its own on something that is this consequential to America? One-sixth of our economy is represented by health care.

Essentially, what they are saying is, we want to expand that part of the economy that isn't working today, that is headed for bankruptcy, that underreimburses doctors and hospitals, put more money into that failed system, exacerbate the cost-shift problem by forcing people in the private-payer market to pay higher premiums. It seems like this creates all sorts of problems that make matters even worse.

I appreciate my colleague's leadership on this issue of pointing out what inevitably is going to happen. When you have the Washington Post editorial this morning even acknowledging the terrible problems this creates for health care and the way this is being conducted, sausage being made here in Washington, DC. Even by Washington's twisted standards, this process has become so dysfunctional, I don't know how they can recover.

One thing they could do is decide to sit down with Republicans and actually figure out some things we could do that would drive health care costs down, rather than making them go up.

Mr. MCCAIN. I thank the Senator from South Dakota. I have to say I have never, in the years I have been here, seen a process such as this. It is incredibly bizarre that after a year, after hundreds of hours in the HELP Committee, after how many hundreds of hours in the Finance Committee, products are here on our desks. Yet there is a meeting yesterday of the Democrats. They come out, and they don't know what the proposal is either. Apparently, there is only one Senator who knows what the proposal is and that is the majority leader. Also, then it is OK to go home for the weekend. I honestly say to my colleague from South Dakota, I have never seen anything quite like this, especially when we are talking about one-sixth of the gross national product. Of course, already from what they know, the hospitals and doctors and others have come out in strong opposition to expansion of a program, as the Senator points out, that is going broke.

Mr. MCCONNELL. I say to my friend from Arizona, he made reference today to the senior Senator from Maine and her very insightful and thoughtful and correct speech a couple weeks ago about how an issue of this magnitude was historically dealt with here and how it was not being dealt with this way. She pointed out, major domestic legislation in modern U.S. history was, without exception, done on a largely bipartisan basis. That whole process, as the Senator from Maine pointed out, has been entirely missing, as we have moved along toward developing this 2,074-page monstrosity of a bill, designed to entirely restructure one-sixth of our economy on a totally partisan basis.

I don't think that is what the American people had in mind. They want us here, as we have all indicated, debating, discussing, and amending this proposal. That is what we would like to do for as long as it takes.

Mr. ALEXANDER. Mr. President, if the Republican leader will think back

when he first came to the Senate as a young aide in 1969, the year before I was a young aide in the Senate,

I can remember President Johnson, a Democrat, and Everett Dirksen, the Republican leader, dealing with the open housing legislation in 1968, a very controversial bill. How did they deal with it? The Democratic President had the bill literally written in the office of the Republican leader, with staff members and Senators trooping in and out. The country looked to Washington and said: Well, the Republican leader and the Democratic President both think it is important. They are trying to work it out. In the end, they voted for cloture. In the end, they got the bill.

Mr. MCCONNELL. My friend from Tennessee is entirely correct. Right before we got here—right before we got here—in 1964 and 1965, the Democrats had overwhelming majorities, as they do now, and the civil rights bill of 1964 and the voting rights bill of 1965 passed on an overwhelming bipartisan basis. The leader of the Republicans, Everett Dirksen, was every bit as much involved in that, if not more involved in it, than even the Democrats. Republicans supported it. On a percentage basis, a greater number——

The PRESIDING OFFICER (Mr. BURRIS). The minority time has expired.

Mr. MCCONNELL. Mr. President, I ask unanimous consent for 1 more minute.

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

Mr. MCCONNELL. An even greater percentage of Republicans ended up supporting the civil rights bills of 1964 and 1965 than Democrats. But it was a truly bipartisan landscape for our country—a landmark, important. It was widely accepted by the American people because of the broad bipartisan support it enjoyed. That is what has been lacking here from the beginning.

Mr. MCCAIN. Mr. President, I ask unanimous consent that a list of physician organizations that oppose this act, representing nearly one-half million physicians, be printed in the RECORD.

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

PHYSICIAN ORGANIZATIONS THAT OPPOSE SENATE'S PATIENT PROTECTION AND AFFORDABLE CARE ACT

To date over 40 state, county and national medical societies, representing nearly one-half million physicians, have stated their public opposition to the Senate healthcare overhaul bill, the Patient Protection and Affordable Care Act (H.R. 3590). It is time for Congress to slow down, take a step back, and change the direction of current reform efforts to ensure that it is done right!

NATIONAL MEDICAL ASSOCIATIONS

American Academy of Cosmetic Surgery, American Academy of Dermatology Association, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology Head and Neck Surgery, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons, American College of Obstetricians and Gynecologists, American College of Osteopathic Surgeons, American College of Surgeons, American Osteopathic Academy of Orthopaedics, American Society for Metabolic & Bariatric Surgery, American Society of Anesthesiologists, American Society of Breast Surgeons, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of General Surgeons, American Society of Plastic Surgeons, American Urological Association, Association of American Physicians and Surgeons, Coalition of State Rheumatology Organizations, Congress of Neurological Surgeons, Heart Rhythm Society, National Association of Spine Specialists, Society for Vascular Surgeons, Society of American Gastrointestinal and Endoscopic Surgeons, Society for Cardiovascular Angiography and Interventions, Society of Gynecologic Oncologists.

STATE AND COUNTY MEDICAL ASSOCIATIONS

Medical Association of the State of Alabama, California Medical Association, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Kansas Medical Association, Louisiana State Medical Society, Missouri State Medical Association, Nebraska Medical Association, Medical Society of New Jersey, Ohio State Medical Association, South Carolina Medical Association, Texas Medical Association, Westchester (NY) County Medical Society.

DECEMBER 1, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR LEADER REID: On behalf of the over 240,000 surgeons and anesthesiologists we represent and the millions of surgical patients we treat each year, the undersigned 19 organizations strongly support the need for national health care reform and share the Senate's commitment to make affordable quality health care more accessible to all Americans. As you know, we have been working diligently and in good faith with the Senate during the past year and have provided input at various stages in the process of drafting the Senate's health care reform bill. To this end, we have reviewed the Patient Protection and Affordable Care Act of 2009.

As you may recall, on November 4 our coalition sent you a letter outlining a number of serious concerns that needed to be addressed to ensure that any final health care reform package would be built on a solid foundation in the best interest of our patients. Since those concerns have not been adequately addressed, as detailed below, we must oppose the legislation as currently written.

We oppose:

Establishment and proposed implementation of an Independent Medicare Advisory Board whose recommendations could become law without congressional action;

Mandatory participation in a seriously flawed Physician Quality Reporting Initiative (PQRI) program with penalties for nonparticipation;

Budget-neutral bonus payments to primary care physicians and rural general surgeons;

Creation of a budget-neutral value-based payment modifier which CMS does not have the capability to implement and places the provision on an unrealistic and unachievable timeline;

Requirement that physicians pay an application fee to cover a background check for participation in Medicare despite already being obligated to meet considerable requirements of training, licensure, and board certification;

Relying solely on the limited recommendations of the United States Preventive Services Task Force (USPSTF) in determining a minimum coverage standard for preventive services and associated cost-sharing protections;

The so-called ''non-discrimination in health care'' provision that would create patient confusion over greatly differing levels of education, skills and training among health care professionals while inappropriately interjecting civil rights concepts into state scope of practice laws;

The absence of a permanent fix to Medicare's broken physician payment system and any meaningful proven medical liability reforms; and

The last-minute addition of the excise tax on elective cosmetic medical procedures. This tax discriminates against women and the middle class. Experience at the state level has demonstrated that it is a failed policy which will not result in the projected revenue. Furthermore, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues.

This bill goes a long way towards realizing the goal of expanding health insurance coverage and takes important steps to improve quality and explore innovative systems for health care delivery. Despite serious concerns, there are several provisions in the Patient Protection and Affordable Care Act of 2009 that the surgical community supports, strongly believes are in the best interest of the surgical patients, and should be maintained in any final package. Specifically these include: health insurance market reforms, including the elimination of coverage denials based on preexisting medical conditions and guaranteed availability and renewability of health insurance coverage; strengthening patient access to emergency and trauma care by ensuring the survival of trauma centers, developing regionalized systems of care to optimize patient outcomes, and improving emergency care for children; well-designed clinical comparative effectiveness research, conducted through an independent institute and not used for determining medical necessity or making coverage and payment decisions or recommendations; and the exclusion of ultrasound from the increase in the utilization rate for calculating the payment for imaging services.

Further, while redistribution of unused residency positions to general surgery is a positive step in addressing the predicted shortage in the surgical workforce, we believe that the Senate should look more broadly at the issue of limits on residency positions for all specialties that work in the surgical setting that are also facing severe workforce problems.

Finally, we are pleased that you have accepted our suggestion and removed language which would reduce payments to physicians who are found to have the highest utilization of resources—without regard to the acuity of the patient's physical condition or the complexity of the care being provided. We thank you for making this important change.

While we must oppose the Patient Protection and Affordable Care Act as currently written, the surgical coalition is committed to the passage of meaningful and comprehensive health care reform that is in the best interest of our patients. We are committed to working with you to make critical changes that are vital to ensuring that this legislation is based on sound policy, and that it will have a long-term positive impact on patient access to safe and effective high-quality surgical care.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Otolaryngology-Head and

Neck Surgery; American Association of Neurological Surgeons; American Association of Orthopaedic Surgeons; American College of Obstetricians and Gynecologists; American College of Osteopathic Surgeons; American College of Surgeons; American Osteopathic Academy of Orthopedics; American Society of Anesthesiologists; American Society of Breast Surgeons.

American Society of Cataract and Refractive Surgery; American Society of Colon and Rectal Surgeons; American Society for Metabolic & Bariatric Surgery; American Society of Plastic Surgeons; American Urological Association; Congress of Neurological Surgeons; Society for Vascular Surgery; Society of American Gastrointestinal and Endoscopic Surgeons; Society of Gynecologic Oncologists.

DECEMBER 7, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR SENATOR REID: The undersigned state and national specialty medical societies are writing you on behalf of more than 92,000 physicians in opposition to passage of the ''Patient Protection and Affordable Care Act'' (H.R. 3590) and to urge you to draft a more targeted bill that will reform the country's flawed system for financing healthcare, while preserving the best healthcare in the world. While continuance of the status quo is not acceptable, the shifting to the federal government of so much control over medical decisions is not justified. We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy.

H.R. 3590 creates a number of problematic provisions, including:

The bill undermines the patient-physician relationship and empowers the federal government with even greater authority. Under the bill, (1) employers would be required to provide health insurance or face financial penalties; (2) health insurance packages with government prescribed benefits will be mandatory; (3) doctors would be forced to participate in the flawed Physician Quality Reporting Initiative (PQRI) or face penalties for nonparticipation; and (4) physicians would have to comply with extensive new reporting requirements related to quality improvement, case management, care coordination, chronic disease management, and use of health information technology.

The bill is unsustainable from a financial standpoint. It significantly expands Medicaid eligibility, shifting healthcare costs to physicians who are paid below the cost of delivering care and to the states that are already operating under severe budget constraints. It also postpones the start of subsidies for the uninsured long after the government levies new user fees and new taxes to cover expanded coverage and benefits. This ''back-loading'' of new spending makes the long-term costs appear deceptively low.

The government-run community health insurance option eventually will lead to a single-payer, government run healthcare system. Despite the state opt-out provision, the community health insurance option contains the same liabilities (i.e., government-run healthcare) as the public option that was passed by the House of Representatives. Such a system will ultimately limit patient choice and put the government between the doctor and the patient, interfering with patient care decisions.

Largely unchecked by Congress or the courts, the federal government would have unprecedented authority to change the Medicare program through the new Independent Medicare Advisory Board and the new Center for Medicare & Medicaid Innovation. Specifically, these entities could arbitrarily reduce payments to physicians for valuable, life-saving care for elderly patients, reducing treatment options in a dramatic way.

The bill is devoid of real medical liability reform measures that reduce costs in proven demonstrable ways. Instead, it contains a ''Sense of the Senate'' encouraging states to develop and test alternatives to the current civil litigation system as a way of addressing the medical liability problem. Given the fact that costs remain a significant concern, Congress should enact reasonable measures to reduce costs. The Congressional Budget Office (CBO) recently confirmed that enacting a comprehensive set of tort reforms will save the federal government $54 billion over 10 years. These savings could help offset increased health insurance premiums (which, according to the CBO, are expected to increase under the bill) or other costs of the bill.

The temporary one-year SGR ''patch'' to replace the 21.2 percent payment cut in 2010 with a 0.5 percent payment increase fails to address the serious underlying problems with the current Medicare physician payment system and compounds the accumulated SGR debt, causing payment cuts of nearly 25 percent in 2011. The CBO has confirmed that a significant reduction in physicians' Medicare payments will reduce beneficiaries' access to services.

The excise tax on elective cosmetic medical procedures in the bill will not produce the revenue projected. Experience at the state level has demonstrated that this is a failed policy. In addition, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues. Physicians strongly oppose the use of provider taxes or fees of any kind to fund healthcare programs or to finance health system reform.

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

Senator Reid, we are at a critical moment in history. America's physicians deliver the best medical care in the world, yet the systems that have been developed to finance the delivery of that care to patients have failed. With congressional action upon us, we are at a crossroads. One path accepts as ''necessary'' a substantial increase in federal government control over how medical care is delivered and financed. We believe the better path is one that allows patients and physicians to take a more direct role in their healthcare decisions. By encouraging patients to own their health insurance policies and by allowing them to freely exercise their right to privately contract with the physician of their choice, healthcare decisions will be made by patients and physicians and not by the government or other third party payers.

We urge you to slow down, take a step back, and change the direction of current reform efforts so we get it right for our patients and our profession. We have a prescription for reform that will work for all Americans, and we are happy to share these solutions with you to improve our nation's healthcare system.

Thank you for considering our views.

Sincerely,

Medical Association of the State of Alabama, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Kansas Medical Society, Louisiana State Medical Society, Missouri State Medical Association, Nebraska Medical Association, Medical Society of New Jersey, South Carolina Medical Association, American Academy of Cosmetic Surgery, American Academy of Facial Plastic and Reconstructive Surgery, American Association of Neurological Surgeons, American Society of Breast Surgeons, American Society of General Surgeons, Congress of Neurological Surgeons.

Past Presidents of the American Medical Association: Daniel H. Johnson, Jr., MD, AMA President 1996–1997; Donald J. Palmisano, MD, JD, FACS, AMA President 2003–2004; William G. Plested, III, MD, FACS, AMA President 2006–2007

Mr. McCAIN. Mr. President, I thank the Senator from Montana for his courtesy.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I must say, some of the debate on the other side of the aisle is a little surreal. They say they want to move ahead, and then they refuse to enter into any reasonable time agreement to consider a necessary appropriations measure. I find it very impressive—I am very impressed—how the minority can maintain both that they want to move more quickly and not move at all—surreal.

I wish to also explain, despite what the claims on the other side are, that we have attempted mightily to work together on both sides of the aisle to get health care reform passed. They claim it is all one-party rule. Nothing could be further from the truth. Let me explain why.

When we began this effort over a year ago, we had many hearings. In fact, last year I think I had 10 hearings in the Finance Committee on health care reform to educate ourselves because we knew health care reform was going to be a big issue in the year 2009. So, in 2008, we had many Finance Committee hearings on all different aspects of health care. How does our system work? How do parts fit together? How does this all work? We were there to educate ourselves. We did not have a political ax to grind. We were not trying to make points. We got the experts in and asked: How does it work? How do the different parts of our system work together?

Then we issued a white paper. It was in November of last year. It was basically a call to action, which is what we called it. It was about an 80-, 90-page paper. It was a statement of the health care options: delivery system reforms, various ways to get increased health

care coverage, various ways to help with insurance market reform—lots of different provisions.

I might say, casting all modesty to the wind, that white paper, that call to action, back in November of 2008, is probably the basis and springboard from which most of the ideas we have been debating, both in the House and in the Senate and on both sides of the aisle, come from. They basically come from there.

I might say, it has all been totally transparent. It is all on the Internet. It has all been open for everybody. Republicans and Democrats participated fully. First was the Library of Congress all-day session, both sides fully—that was over a year ago.

Since then, in 2009, this year, we have had a countless number—in the Finance Committee—of what we call roundtables, a countless number of walk-throughs, a countless number of hearings on all the various aspects of health care reform—bipartisan, fully open.

Also, I instituted something else here; that is, we got to the point where we finally got to the markup, and we put the marked up bill on the Internet, again, so everybody sees everything. We also made sure all amendments were on the Internet and fully debated by both sides—totally open, totally transparent. I prided myself on doing that.

In fact, one very well-known health journalist who works for a very major paper walked up to me and said: MAX, is this a new way of doing things? Maybe you started something, MAX, in being so transparent and working so much together. Do you think this is the model for the future? I said: I don't know. But it impressed him how much we tried to work together and did work together with people on both sides of the aisle.

I cannot think of a more comprehensive, more transparent, more bipartisan effort than this.

So what happened? Well, the HELP Committee had their version passed. So we in the Finance Committee worked on ours. To move the ball, I shifted it to another group—we called it the Gang of 6; three Republicans, three Democrats—to try to get a core provision together that we could take to the full committee.

We had a countless number of meetings. I have forgotten the number of days we met—I think in the nature of 30 or 40 meetings and close to 100 hours and with Republicans and Democrats to and fro. Guess what. It was very, very constructive. I wish the American public could have been an eye on the wall at those meetings and watched these meetings proceed. There were very good questions asked by Senators on both sides, Republicans and Democrats.

I highly compliment my friend from Wyoming, Senator ENZI. I highly compliment my friend from Maine, Senator SNOWE. I highly compliment everybody who was there. They asked very good questions—and Senator GRASSLEY, of course, he is the ranking member of the Finance Committee; and the same on the Democratic side—in an effort to try to find a good, solid health care reform bill.

Well, we kept working—bipartisan—working together for days, days, hours, hours. Then, unfortunately, we got to the point where—I am just calling it as I see it; one of my failings is I am too honest about things—and the Republicans started to walk away. They pulled away from the table. They had to leave.

I ask you, why? Why did that happen? The answer—to be totally fair and above board—is because their leadership asked them to. Their leadership asked them to become disengaged from the process. I know that to be a fact. Why did their leadership ask Republicans to leave and become disengaged from the process? To be totally candid, it is because they wanted to score political points by just attacking this bill. They were not here to help be constructive, to find some bipartisan solution. They were for a while. Then, when the rubber started to meet the road, when it came time to try to make some decisions, they left and began to attack.

I think a big, unfortunate circumstance in all this—we are going to pass health care reform. It is going to pass. It is going to do wonders for the American people. We are going to dramatically reform the health insurance market. People are going to have health insurance they do not now have. We are going to help put in place delivery system reforms. That is just a fancy term for saying changing the way we reimburse hospitals and doctors in a very positive way, so we are focusing more on quality and less on quantity and volume. This bill is going to pass. It is going to be a very good bill when it finally does pass and people understand it.

But the unfortunate part is this: It is unfortunate, in my judgment, that the other side pursued a strategy of just saying no, just saying no, and attack, attack, attack. That is basically what we have heard here in the last several weeks, instead of coming up with a comprehensive alternative, instead of coming up with a comprehensive alternative health care reform package. Then it would have been wonderful if we had an honest-to-goodness, solid debate on the pros and cons of each side, the merits of each side, a constructive dialog, pursuit, inquiry, focus on which portions of this should be put in the bill and which should not. But that did not happen. We did not have this constructive alternative provision presented to us. We had no provision presented to us—and by ''to us,'' I mean the American public—so we could debate here. But, rather, they just said no.

We have worked as hard as we could to be bipartisan. But to be honest and candid about it, the other side walked away. They walked away, and I think it is very unfortunate that happened.

Mr. President, I yield 5 minutes to the Senator from Massachusetts, Mr. KIRK.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KIRK. Mr. President, before I say anything else, I wish to, once again, commend the Senator from Montana for his leadership on this historic piece of legislation. It is going to have an impact on people more widely and broadly than our Social Security system, and this will be as important a domestic piece of legislation as that. Every American who looks forward to their golden years knows what Social Security means.

The Senator from Montana has quite correctly mentioned how this legislation will have an impact on people's lives. I have only been in the Senate a short period of time, but I cannot tell you the numbers of constituents who have communicated with me about their situation in the Commonwealth of Massachusetts; whereas, in 2006, Massachusetts enacted health care reform, many of the aspects of that legislation are contained in the bill we are debating.

For the record, today the Boston Globe published a story indicating that more than 96 percent of the State's adult taxpayers had health insurance in 2008. This is close to universal coverage, and I am sure, before too long, we will be able to say we hit the 100-percent mark.

This is providing affordable insurance to people who otherwise would never have had it. When the Senator from Montana talked about how this bill would impact people's lives, I am going to tell you a story that was told to me by a family who had a situation. I will call them Daniel and Brenda. Those are their names.

They had been living without health insurance for years. In fact, Brenda said she could barely remember when they had last gone to the doctor because they did not have health insurance. But she learned about our Health Care for All on the Helpline that is in existence in Massachusetts from a close friend. Soon after she contacted it, her husband was diagnosed with a serious heart condition. With the indispensable assistance of the Helpline, her family was able to enroll in coverage they could afford.

Brenda's husband Daniel had started to feel constant fatigue. He never imagined that someday he would need to have a strong supporting device inserted in his heart. Brenda said they truly appreciated all the assistance given to them through the Helpline. But there is more.

Brenda and Daniel recently welcomed a new addition to their family. Unfortunately, their son was born with respiratory problems and had to stay in the intensive care unit for 7 days immediately after his birth. Brenda told

us she had a hard time leaving the hospital without her newborn son in her arms. But she could also take comfort in being surrounded by top medical professionals who were dedicated to caring for her son. Here is what she wrote:

Health Care for All has been such a gift to our lives. First, my husband had no idea of the seriousness of his health issue. If it wasn't for our eligibility with the [State's new health care reform] programs, we would probably have found out about his heart disease too late. And right after came the unexpected surprise of having my son in neonatal care for a week. Both of these situations were hard to go through just emotionally. We just couldn't imagine how it could have been hard financially speaking. That's why, and for many other reasons, we are just so amazed to be Massachusetts residents and count on the tremendous support we have been receiving from the Helpline counselors.

This is just one example of countless families I have heard from in Massachusetts.

It clearly shows how important it is to pass national health care reform and enable all Americans to have the quality, affordable health care that Brenda, Daniel, and their son were able to have.

So I wanted to bring to the attention of our colleagues in the Senate a real life story of what health care reform can mean and what will be great relief for the financial and health security to American families when we enact this legislation.

I ask unanimous consent that the Boston Globe article I mentioned be printed in the CONGRESSIONAL RECORD.

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

[From the Boston Globe, Dec. 10, 2009]

FEWER TAXPAYERS ARE PENALIZED FOR NOT HAVING HEALTH COVERAGE

(By Elizabeth Cooney)

Fewer Massachusetts taxpayers were penalized for lacking required health insurance last year than were fined in 2007, the state said yesterday in a report reflecting the second year that residents had to report on their tax returns whether they were covered under the state's near-universal-coverage mandate.

More than 96 percent, or 3.8 million, of the state's 3.95 million adult taxpayers said they had health insurance for at least part of 2008, according to the state Department of Revenue, and 3.65 million had coverage for the entire year.

About 45,000 tax filers did not have health insurance, although they were classified as able to afford it under state guidelines. They paid a penalty of up to $76 for each month they went without coverage, depending on a sliding scale matched to their income. Another 8,000 successfully appealed their penalties, based on hardship, to the Commonwealth Health Insurance Connector Authority.

In 2007, when 95 percent of tax filers said they were insured, more people were fined: 60,000 people lost their personal exemption, about $219 for an individual, for not having health insurance that year.

''This report gives us yet another data point demonstrating the continued success of health reform with exceptionally high rates of insurance and a smooth system for the mandate in the Commonwealth,'' Lindsey Tucker, health reform policy manager at the advocacy group Health Care For All, said in an e-mailed statement.

''The report also reminds us of one of the major gaps in our reform: the thousands of residents unable to purchase insurance due to its lack of affordability,'' she said. ''We must continue to search for ways to keep quality coverage affordable for all our residents.''

The penalty, which is pegged to one half the cost of the lowest premium offered by the Commonwealth Connector, went up to a maximum of $89 a month for 2009, and the Revenue Department has proposed raising it to $93 in 2010.

People who are deemed unable to afford insurance are not penalized, and those who have a lapse of up to three months in their coverage are also not subject to the penalty.

The high percentage of tax filers reporting they have insurance fits with other state reports saying that 97 percent of all residents have coverage, Navjeet K. Bal, commissioner of the Department of Revenue, said in an interview.

''From 2007 to 2008, we did not see a real drop in health insurance,'' she said. ''Even with the economic turmoil that started in [fall] 2008, people still had health insurance. A year from now, we'll see.''

Mr. KIRK. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I rise this afternoon to speak on two subjects as part of our health care debate. The first is what happens to our children. We have had an opportunity over the last couple of weeks, and will continue to have a full debate about so many aspects of this legislation. When it comes to the question of what happens to our children—and I speak of in this case poor children and special needs children—I have said from the beginning of this debate and even before the debate began many months ago that the standard ought to be four words: No child worse off. It is a very simple standard. I think it is a standard we can meet and I believe it is a standard we should meet for the most vulnerable children in America—those who happen to be poor or suffer from or are burdened by special needs, both the impact on that child, that individual life, as well as the impact on his or her family.

The good news is that over the last couple of years, we have gotten it right with regard to children's health insurance, a program I am proud to say had a good bit of its foundation and its origins in Pennsylvania. It became a national effort in 1997 when President Clinton signed the legislation. We have had, frankly, a lot of bipartisan support for this program over many years, although we had less bipartisan support when it was reauthorized this past year when President Obama signed it into law.

Here is what it means. The Children's Health Insurance Program, known by the acronym CHIP, has provided millions of children with health insurance coverage they would never have absent that program. We don't know the exact number as we speak today, but we are at a point now where we have in the range of 7 million or more children covered. Over the next couple of years, we will have 14 million American children covered. That is an enormous achievement, but more important than any kind of legislative achievement, it will mean that 14 million children or their families won't have to worry about whether they get quality health care.

In the first year of a child's life, the experts tell us they should get to the doctor at least six times for a so-called well child visit. A Children's Health Insurance Program in America ensures these children receive many benefits, including dental, immunization, and preventive care. But the fact I always point to is that for six times in the first year of a child's life, he or she will get to see a doctor because they are in the CHIP program, and that has an enormous impact for that one life, for that one family, but I would argue—and I think the evidence is irrefutable—it will have a positive impact on all of our lives, because of the impact of millions of children getting that kind of help in the early years of their life.

We know this program works. The Children's Health Insurance Program works. That is an understatement. It works well.

What we are worried about, though—what I am worried about—is that there have been people in Washington who have advocated putting the Children's Health Insurance Program in the new insurance exchange. The exchange is going to be a very positive development for our health care system and for adults, but I would argue strongly and vigorously that it is not good for kids. So we are going to be debating that maybe in a couple of years, but we want to make sure as we debate that question that we have as much evidence to show that and put forth the reasons why the Children's Health Insurance Program should not—should not—be part of the exchange.

In terms of why we say that, the research on this question is indisputable. The director of CBO, the Congressional Budget Office, Doug Elmendorf—and we know a lot about CBO. They make determinations about this bill and about costs. CBO has said that children will have better benefits and more cost savings in CHIP than they will in the exchange.

Yesterday, an organization many people here know as First Focus released a white paper which compared Children's Health Insurance coverage versus coverage those children would get in the exchange. Here are some of the results of that research paper.

No. 1, the question of children's coverage from 2009 through 2013:

If health reform were to repeal CHIP in 2013, States would not invest in improving coverage for those children when those very efforts will be dismantled just a few years later.

It stands to reason. Why would a State go forward to strengthen a program they know is going to change as

a matter of Federal policy a couple of years later?

The increased coverage of 4 million children that is expected from passing Children's Health Insurance legislation earlier this year would be largely lost.

That whole effort that took years—years—and two Presidential vetoes, before President Obama became President, to get to continue the CHIP program and expand.

No. 2, First Focus, another one of their conclusions:

Children in most State Children's Health Insurance Plans receive coverage for all approved vaccinations, dental care and well-baby and well-child visits. This level of benefits stand in contrast to private plans, like those in the exchanges.

What is good for an adult may not be good for a child. Children are not small adults as so many advocates have said over and over. But the level of benefits that children get in CHIP stands in contrast to the provisions in private plans such as those in the exchange which often impose limits that are particularly harmful to low-income children and children with special needs.

That is conclusion No. 2 by First Focus.

Conclusion No. 3 is the following:

An actuarial study—

A recent study—

finds that children moved from CHIP to the exchange plans would dramatically increase out-of-pocket costs for those kids. Out-of-pocket costs for a child living in a family earning 225 percent of the Federal poverty level would increase by 1,100 percent—

not 1,100 dollars, but 1,100 percent—

if the Senate were to join the House in repealing Children's Health Insurance Program.

This is another reason why it is a bad idea. We want to make sure this program is strong. We know it works. We also don't want to exponentially, radically increase out-of-pocket costs.

Conclusion No. 4, premiums:

Because Children's Health Insurance keeps premiums and other out-of-pocket costs for children at low levels, the cost of health insurance exchange plans will be many times higher than that, even for just covering children.

An increase in premiums will lead to a number of children currently enrolled in CHIP to lose coverage—to lose coverage—according to the Congressional Budget Office.

No. 5, reason to do the right thing, access to pediatric providers:

Children's Health Insurance plans specifically focus on the unique health care needs of children, which is not the case in the proposed exchanges. The recent Children's Health Insurance reauthorization—

For those who watch these Senate debates, we use words such as ''reauthorization.'' My simple way of saying that is we do it again. We take an existing program, evaluate it, see if it is working, and keep doing it. That is what reauthorization is all about. But we did that earlier in the year, thank goodness, for children's health insurance.

The recent effort to continue CHIP included improvements to pediatric-specific quality measures that may get lost in the conversion of CHIP as a stand-alone program put into the exchange. We don't want to do that for kids. We want to make sure every pediatric-specific quality measure that we have in place now, all of these years later, is maintained. We don't want to injure that. We don't want to cut that back.

Finally, in terms of another item on the list of reasons, guarantee to care:

In exchange plans, some children currently eligible for the Children's Health Insurance Program may be barred—may be barred—from receiving subsidies for coverage due to the cost of employer-sponsored plans.

Once again, what is good for an adult may not be good for our kids. We have to watch this.

Moreover, the families that are eligible for subsidies and coverage through exchange plans may find coverage so unaffordable that they are left without insurance entirely.

So we don't want to send a family into the exchange who is trying to get insurance for themselves and their kids and find out that they can't cover their kids because it costs too much. We have an existing, stand-alone Children's Health Insurance Program that we know works.

This amendment I filed for this debate on health care—the children's health insurance amendment to guarantee that we keep it strong, strengthen it and continue it—the Children's Health Insurance Program has the support of over 500 national and State organizations that focus on children's health, health policy generally, social workers, children's mental health advocates, school educators, health plans in particular, faith groups across the country, and more. These 500 national and State organizations speak volumes about why this amendment is so important. We must strengthen and ensure the continuity of CHIP in this health care reform bill. That is what our amendment is all about.

Mr. President, I ask unanimous consent to hae printed in the RECORD a letter addressed to me, dated December 9, from more than 500 organizations.

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

DECEMBER 9, 2009.

Hon. ROBERT P. CASEY, JR.,
U.S. Senate,
Washington, DC.

DEAR SENATOR CASEY: As organizations committed to ensuring that all of our nation's children get the health coverage they need and deserve, we are writing to thank you for your commitment to making children an important priority by filing Amendment #2790 to the Patient Protection and Affordable Care Act (H.R. 3590). Your amendment builds on the provisions of the underlying bill, continuing to protect and improve the country's successful Children's Health Insurance Program (CHIP) and ensuring that no child ends up worse off as a result of health reform. We applaud your leadership.

America's children have a lot at stake in health reform. More than eight million children remain uninsured, and more are losing employer-sponsored coverage daily. Families are just one playground accident away from medical bankruptcy. Each day a child is uninsured is a lost opportunity to strengthen our next generation, America's future. Your amendment goes a long way toward protecting and improving coverage for millions of children in low-income working families across the nation by:

Providing full funding for CHIP through 2019;

Maintaining current CHIP eligibility through 2013, and setting a floor for income eligibility for children in all states at 250 percent of poverty ($55,125 for a family of four) beginning in 2014;

Streamlining enrollment procedures making it easier for children to get coverage and keep it;

Ensuring that coverage for children remains affordable;

Guaranteeing all children in CHIP the comprehensive care they need from head to toe; and

Requiring an HHS report in 2016 that will compare coverage for children in CHIP with coverage for children in the new Health Insurance Exchange and if coverage (including benefits, cost-sharing, premiums, and other features) is comparable or better, children can be transitioned from CHIP into the Exchange in 2019.

Our nation has made great strides over the last decade in securing health coverage for low-income children of working families. We must now seize this historic opportunity to build on the success of prior efforts and the bipartisan CHIP program, and ensure that children will be better off, not worse off, as a result of health reform. Your amendment will do just that.

We offer our strong support for your CHIP Amendment (#2790). We stand ready to work with you and your Senate colleagues to achieve our common goal of reforming our nation's health care system and ensuring that *all* children, indeed everyone in America, have access to the health coverage they need and deserve.

Sincerely,

National Organizations.

Mr. CASEY. Thank you very much. I wish to inquire as to how much time I have.

The PRESIDING OFFICER. There is 3½ minutes remaining.

Mr. CASEY. I will move quickly.

The second part of my remarks focuses on pregnant and parenting teens and women. We have an amendment that focuses on a group of pregnant women in America that we are not doing enough about. Neither party, in my judgment, is doing enough about them, enough about help for those women. I will come back to this maybe later today. But it is vitally important, whether we are Democrats, Republicans, or Independents, but as Americans, that we give integrity and meaning to the sentiment that is often expressed that we care about pregnant women, that we care about a teen mother who decides to bear a child, that we are going to help her through if she makes that decision.

If a woman on a college campus becomes pregnant and decides to have that child, we want to give her all the help we can. If a woman is a victim of domestic violence or other sexual violence or stalking, and through all of the horrific nightmare of that violence,

she determines that she is going to go through with a pregnancy and have a child, that we help her in the midst of that darkness, that we give her some light in that darkness. What we don't want to have is women who are deciding to bear a child who feel all alone, who have to walk that path all by themselves.

That is what this amendment is about. I will return to it later today.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that we be able to go into a colloquy for the next half hour.

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

Mrs. HUTCHISON. Mr. President, I rise today to talk about the taxes that are in this bill—taxes that are imposed in 3 weeks—not 3 weeks from 6 months from now, not 3 weeks from 2014, but 3 weeks from now, January 1, 2010. Three weeks from now, on January 1, 2010, we are going to see the taxes in this bill start.

I know people are saying: Wait a minute. This bill doesn't take effect until 2014. That is what we have been talking about. It is what we have been hearing. But, no, the tax part starts in 3 weeks—January of 2010.

I have partnered with Senator THUNE, who has been working on this problem, and Senator GRASSLEY and Senator HATCH and many others who will be speaking today.

I see my colleagues from Florida, Nebraska, Wyoming, as well as my colleague, Senator CRAPO, from Idaho, all of whom—Senator CRAPO, of course, is waiting for a vote on his amendment, which would stop the taxes on everyone who makes $200,000 or less.

We are talking about the taxes because it is such a huge issue. Here is what is going to happen with the taxes in the bill that start in 3 weeks. Americans will pay more in insurance premiums. Americans will pay more in prescription drugs. Americans will pay more for medical equipment. Let's walk through those taxes.

In a few weeks, in January of 2010, this will begin: $22 billion in taxes on prescription drug manufacturers; $19 billion in taxes on medical device manufacturers; $60 billion in taxes on insurance companies. That is around $100 billion, which starts in 3 weeks. Then, in 2013, the taxes on high-benefit plans take effect. That is $150 billion in taxes. So for every union member who has a good plan that gives them the benefits they have negotiated for over the years, those taxes come in at 40 percent of the benefits. That starts in 2013.

You are still saying: Wait a minute. I thought the bill started in 2014—and that is right. But the taxes start in 3 weeks, and they keep right on going. In 2013, the high-benefit plans start getting a 40-percent excise tax.

Mr. President, when the $100 billion in taxes start in 3 weeks on drug manufacturers, medical device manufacturers, and insurance companies, what happens? Premiums go up immediately, prescription drug prices go up immediately, and the medical devices—hearing aids and things people need for medical treatments—go up immediately.

We have been talking about health care reform and the need for it, and the need to make history. Yet the reform we are going to see go into effect right away is huge tax increases. I am here with many colleagues, who are so concerned about this for their constituents.

I ask the Senator from Wyoming, who is one of the two physicians in the Senate—he has been so active in this area. When the taxes go up on our insurance premiums, our prescription drugs, and our medical equipment, I ask the Senator from Wyoming, as a physician, what does he think is going to happen to the cost of health care.

Mr. BARRASSO. Mr. President, I have great concern about the cost of health care for American families. We see it with our seniors certainly, as they will be seeing Medicare cuts. In this bill, there is $464 billion in Medicare cuts, but there are taxes that are going to go up, which will impact all of the people in this country.

I remember a promise the President made. He said his plan would not raise taxes one penny. He went on to say: not your income taxes, payroll taxes, capital gains taxes—any of your taxes.

We are seeing that taxes are going up, and in a way that is basically—you hate to say it, but it is a gimmick in this bill, where they are going to collect taxes for 10 years but only give benefits for 6, and it is the last 6 years.

As my colleague from Texas said, they are going to start collecting taxes—today is December 10—on the 31st of this month, 21 days from now, but the services would not be given for 4 years. That is how they get the number under $1 trillion, and it is at a time when the President makes a statement that this would not add a penny or a dime to the deficit. Eighty percent of the American people don't believe it because they know what is in front of them. They know what it is like to live their own lives. Is this what the Senator from Texas is seeing as well?

Mrs. HUTCHISON. The President said, in his address to the joint session of Congress, that this bill had to come in at a cost of no more than $900 billion. So the CBO scored the bill at $847 billion. But the Senator from Wyoming has brought up a point that is because they started scoring the bill in 2010, but the services in the bill don't start until 2014.

If you take the years from 2010 to 2019, it probably comes in at $847 billion. But if you start when the spending starts and go to 2023, the cost is $2.5 trillion.

I just ask the Senator from Nebraska if his constituents are hearing of this $2.5 trillion cost, with one-quarter of it coming from Medicare cuts and about one-quarter of it in new taxes that start next week. What does the Senator from Nebraska say about this?

Mr. JOHANNS. Mr. President, the citizens from Nebraska are absolutely on to this gimmick. They know it is a gimmick. Here is what I tell the Senator from Texas: I had an opportunity, as she knows, to be their Governor for 6 years. Every year, I had to walk in front of the unicameral—our one-house system—and give a state of the State address and lay out a budget plan. If I had walked into that chamber with a budget plan with these kinds of gimmicks, they would have been rolling in the aisles laughing at me, literally. They would have been rolling in the aisles.

I always did a State fly-around, where I visited the communities and talked about my budget vision and my legislative package, et cetera. The people of Nebraska would have run me out of the State had I tried to balance the State budget based upon this kind of gimmicky approach.

The Senator has absolutely hit the nail on the head. What we have here is a situation where those who wrote this bill—as we all know, it was written behind closed doors and nobody knew what the bill was until a few weeks ago—but those who wrote the bill said: Oh my goodness, the President has said we have to bring this bill in under $900 billion. That is what he said. How are we going to get that accomplished? So they used gimmicks. They uploaded the bill, front-end loaded the bill on the revenues, so that starts right away. Then the benefits don't start for 3 or 4 years. So it is magic; we have made the bill come in under $900 billion.

Let me offer this thought: Who loses on this crazy accounting gimmick? Do you know who loses? The constituents we represent in the United States—not just in Nebraska. They are going to pay the taxes. They are not going to see the benefits. It is like buying a car and paying on it for 4 years but not getting the car for 4 years. They are going to pay on it.

Sadly, and most concerning to me, is that this gimmickry is going to be passed on to the next generation because, when it doesn't work, somebody has to pick up the bill. The full cost of this bill, we have come to recognize, is $2.5 trillion. This bill doesn't fit together. It doesn't pass the smell test, as we say back home in Nebraska.

My hope is that sanity will revisit what we are doing and people will say: Time out. We can't ask the American people to go along with this. We have to call a timeout and get this right.

Mrs. HUTCHISON. I thank the Senator from Nebraska. I think having been a former Governor, his view is especially important. What we have heard through the grapevine—we haven't seen any new proposals, but we heard there is going to be an expansion of Medicare and an expansion of Medicaid. Medicaid, in particular, is going

to be very costly to States because they have a matching requirement for Medicaid. Many Governors are concerned about that.

I know the former Governor of Nebraska, in his background, realizes that is one of the biggest issues in a State's budget.

I know the Senator from Florida also has experience with being in a Governor's office, being a chief of staff for a Governor. He has been very active, especially because the population of Florida has a very high rate of senior citizens. The cuts in Medicare in the bill are huge. He is on the Senate floor. I am just wondering, when we are looking at the cuts in Medicare and the huge taxes, how that will impact the State of Florida, and how he thinks we are going to have to deal with that.

Mr. LEMIEUX. Mr. President, I thank the Senator from Texas. This is budget gimmickry. As the Senator from Texas said, as a former chief of staff who worked on trying to balance the budget because our constitution in Florida requires that, we try to figure out how much revenue we have and how much we can spend. If there were not enough revenues, we either had to cut spending or find a new source of revenues. We could not engage in this budget gimmickry.

If I may borrow an analogy from my friend from Nebraska, this is like paying for a car for 4 years before you even get to drive it. Imagine you are going to make a substantial purchase—a house or car—and they show you the house, and they say here is your mortgage payment, and you will live in the house for 10 years, but you will start paying for it today. But you can't move in until 2014. That is what this bill does.

In order to make this ''budget neutral,'' we steal $½ trillion from Medicare—health care for seniors, which seniors have paid into—and we raise taxes, which is going to increase, not decrease, the cost of insurance. When we tax pharmaceutical companies and tax the providers of medical devices, what happens? They pass those costs right along to the citizens. Not only are we stealing from Medicare, not only are we raising taxes, which will be passed on to the citizens, now we are going to tell the States we are going to increase Medicaid.

We are hearing about this secret deal that has been put together behind closed doors. My friends are in the dark, and a lot of Democrats don't know what is going on either. They are trying to figure out what the deal is. The deal will put more of a burden on the States.

I know my friend from Nebraska knows this, being a former Governor. The American people need to know, when you increase Medicaid, the States pay the vast majority of that; and because they have to balance their budget, they will have to cut something else. So they are going to have to cut teachers or law enforcement. So we steal from seniors, steal from the States, raise taxes, and we don't cut the cost of health care for most Americans.

I am new to this Chamber, and perhaps my friend from Idaho can help me understand this. It doesn't make a lot of sense as to how we should proceed with health care reform.

Mr. CRAPO. No, it does not. I appreciate the comments of my colleague from Florida, all my colleagues on the Senate floor today.

As the Senator from Texas indicated, one of the items of business before us today is my motion to commit this bill to the Finance Committee to take out the taxes that the President pledged would not be in there. The President pledged that no one who makes less than $250,000 as a family or $200,000 as an individual will pay any taxes under this bill. Yet in the very first 10 years, there is almost $500 billion of those taxes, a huge portion of which falls on people who are in that category.

As has been indicated, the real implementation of the bill on the spending side does not happen until 2014. If you count the amount of taxes that start when the spending starts, it is about $1.2 trillion of new taxes. Really, the only thing that is transparent—because this was all crafted behind closed doors—the only thing that is transparent is the gimmick.

The President said, as the Senator from Texas pointed out, that he would not let a bill come across his desk and get a signature if it spent more than $900 billion. First of all, you have to say: Wow, why do we need almost $1 trillion of new spending? But when they went behind closed doors and came up with this bill, it turns out it cost around $2 trillion or $2.5 trillion.

How did they make it meet the $900 billion test? They just said: Look, let's delay its implementation for long enough that the number comes out to under $900 billion. That happened to be the year 2014. So if you don't count the first 4 years and only count 6 of the 10, then in this budget window we are working in you can get your number. It is just remarkable.

Before I ask the Senator from South Dakota about his perspective, because I know he is working with the Senator from Texas on an amendment to try to correct this gimmick, I would like to respond to one quick point I know our opposition on the other side has continued to make, and that is they actually say there are no tax increases in the bill.

How do they say that? Here is the way they say it. There are subsidies in the bill that are provided to people with low income who do not have adequate access to insurance. Those subsidies total about $400 billion in the bill in the first 10 years, which is really only 6. They count those subsidies as a tax cut. The technical term given to them is a ''refundable tax credit,'' although $300 billion of those subsidies do not go to taxpayers. The people who receive them do not have a tax liability. But then they offset those subsidies against the taxes the rest of America will pay and say, therefore, there are no taxes in the bill.

I think that is another form of gimmickry. I ask my colleague from South Dakota what his perspective is on the types of gimmicks we are seeing and whether the American people should insist that these kinds of things be removed from the bill.

Mr. THUNE. I say to my colleague from Idaho that I support his motion. I hope we get a chance to vote on it. I know right now they are scrambling to find an alternative to put up so they can have something on which to give their side political cover because they know the reason they are trying so hard is because they know this raises taxes. To say with a straight face this does not raise taxes—the American people get this. I think the gig is up. They figured out there are huge Medicare cuts in this bill, huge tax increases in this bill. And as the Senator from Idaho pointed out, when they say these refundable tax credits are going to go back in the form of premium subsidies and there are not that many people who are going to pay, as he pointed out, 73 percent of the people who will get those premium subsidies are people who do not have an income tax liability already. Therefore, it is hard to say you are going to reduce taxes on somebody who does not have an income tax liability.

More important than that, there are still 42 million Americans with incomes under $200,000 a year, according to the Joint Tax Committee, who are going to see their taxes go up under this bill. So you literally have millions and millions of Americans under $200,000 a year. And as the Senator from Idaho mentioned, the President's promise was he would not raise taxes on anybody earning under $250,000 a year. This flatly contradicts that, flatly violates that pledge. I cannot fathom anybody coming here with a straight face and saying: Oh, yes, this doesn't raise taxes. Of course it raises taxes.

What the Senator from Texas and I intend to do on our motion—and I hope we have a chance to vote on it and the Senator's motion—we will go back to the committee and figure this out. We want to offer a motion that we think makes sense because it aligns and synchronizes the dates of all this.

What has happened here, I would say, in a very deceptive way, is they understated the costs of the bill. My colleagues on the floor already alluded to this. They tried to get it under $1 trillion, and in attempt to get it under $1 trillion, they had to come up with budget gimmicks.

To illustrate that with a bar chart, we can see in the first 10 years of this bill—starting today and going to 2019—the spending in the early years does not show up much. That is because most of the spending gets put off until January 1, 2014.

So if we look at that first 10-year period, the spending under the bill is less than it will be when the bill is fully implemented. When the bill is fully implemented, looking at the years 2014 to 2023, it explodes the spending in the bill from about $1 trillion over the first 10 years to $2.5 trillion over the 10 years when it is fully implemented.

The reason they were able to do that is because of this sort of smoke-and-mirrors way of enacting the tax increases immediately and delaying the spending. The American people are going to end up spending $71 billion in tax increases out of their pockets, out of the American taxpayers' pockets, about $600 per taxpayer, before they ever see a benefit under this bill.

What the Senator from Texas, Mrs. HUTCHISON, and I are offering is a motion that would delay the tax increases until such time as the benefits begin. That, to me, seems to be a fair way to go about making public policy.

What they have done, in an effort to obscure the overall cost of this bill, is to say that 22 days from now, we are going to raise your taxes. On January 1 of this year is when most of these taxes—the taxes on prescription drugs, taxes on medical devices, taxes on health plans—all the taxes in the bill begin to take effect January 1 of next year. For 4 years, people will be paying taxes out of their pockets. I might add, because of the taxes that are going to go on all the device manufacturers, prescription drugs, and health plans, they will get passed on in the form of higher premiums. They are going to see tax increases and premium increases before they ever see a dollar of benefits.

It is 1,483 days until the benefits under this bill kick in. That is unfair. It is unfair to the American taxpayer, it is unfair to the American people, and it is unfair to try to obscure and mask the total cost of this bill and say we are only spending $1 trillion on this bill when we know full well when it is fully implemented, the total cost of that is $2.5 trillion.

I appreciate the discussion that is being held here in pointing out the smoke and mirrors, the sort of underhanded way to try to shield the cost of this bill but also to support the Senator from Idaho with his motion that would commit this bill and get these tax increases out of here because the one thing small businesses are saying right now is we want to invest, we want to create jobs. But you cannot raise taxes on small businesses when you want them to create jobs. That is what this bill does.

The National Federation of Independent Business, the Chamber of Commerce, the National Association of Wholesalers and Distributors—all the major business organizations—have come out opposed to this bill.

The National Federation of Independent Business in a letter yesterday said: We do not support policies that increase the cost of doing business and that raise taxes. Clearly, that is what this bill does.

Our motion is very simple; that is, it simply delays tax increases until such time as the benefits begin.

Mrs. HUTCHISON. I am very pleased that the Senator from South Dakota talked about what we are trying to do because it is very simple. It is very simple. The Hutchison-Thune motion to commit says, if we do nothing else, if we do nothing else in this bill, we have to be fair and transparent with the American people; that is, we do not start the taxes, we do not start the increases in premiums, increases in prescription drug benefits, increases in medical devices until at least there is an implementation of this insurance program that we hear is going to be offered to the American people. We have not seen it, but we are told that there is going to be an insurance program that Americans can sign up for, but they are going to be paying higher taxes and premiums and costs in health care for 4 years before they ever see it. All we are saying is, let's send this bill back to committee and fix that.

It does not—as the Senator from Nebraska said earlier—pass the smell test. It does not pass the smell test in Nebraska, Wyoming, Florida, Idaho, South Dakota, or Texas. To tax people for 4 years, to raise their costs until they basically are going to say, Give me an alternative, and the alternative is, guess what: A big government takeover of our health care system. That is like saying: I am from the Federal Government, and I am here to help you. We have heard that before.

I do not think the American people will in any way believe that this bill is fair or honest with them if we start the taxes 22 days from now, as the Senator from South Dakota has pointed out, but they do not see a program. They are going to go online and say: Oh, my premiums are going up, my prescription drugs are going up; my goodness, where is the insurance program they have been talking about? They are going to go online, but, hey, there is no program.

How can we go home—I ask any of the Senators who would like to add their perspective on this—how are you going to go home and tell your constituents that your taxes start in 22 days, and maybe in 4 years, roughly, maybe you are going to see a program, and we are from the Federal Government, and we are here to help you?

Mr. BARRASSO. You cannot go home and say that with a straight face. There are many rural areas in our States. People see through all this.

There are two articles next to each other in today's New York Times. One talks about the details of the secret agreement they are working on behind closed doors. It says: ''Details Are Scanty.'' Right next to it it talks about: ''For Rural Elderly, Times Are Distinctly Harder.'' These are the people who are going to see taxes going up, these are the people who are going to see cuts in Medicare.

I want to read the first paragraph because this is from Lingle, WY, a community in my State. It talks about Norma Clark, 80. It says:

> Norma Clark, 80, slipped on the ice out by the horse corral one afternoon and broke her hip in four places.

I am an orthopedic doctor. I have taken care of these over the years.

> Alone, it took her three hours—

These are the kind of wonderful Americans we have—

> Alone, it took her 3 hours to drag herself 40 yards back to the house through snow and mud, after she had tied her legs together with rope to stabilize the injury.

This is a person who is on Medicare, and they are going to cut $464 billion from Medicare, and they are going to use gimmicks that are going to harm our people.

I have a former Governor and a former chief of staff for a Governor's office. You know in the rural parts of your community, I say to Governor, now the Senator from Nebraska, you have people like that—hard-working people who expect honesty from a government, and they are not getting it in this bill which is going to tax for 10 years and only give services for 6.

Mr. JOHANNS. That is such a compelling story. I want to add something to that. When you think the policy could not get more crazy and insane, you hear about this idea that they are going to expand Medicare, which is due to be insolvent in 2017. But the tragedy of that in relating it to the story you just told us is this: That will hammer our rural hospitals. Why? Because they cannot stay open on Medicare reimbursement rates. They cannot stay open on Medicaid reimbursement rates.

This poor woman who dragged herself to try to get some care all of a sudden could be faced with the possibility that the hospital she relies on will not stay open under this health care bill.

I have been to those hospitals. I have seen the struggles they are going through with Medicaid and Medicare reimbursement. Every hospital administrator tells me the same thing: We would close our doors if we had to live on that.

So what is their solution? Expand Medicaid and Medicare. You have got to be kidding me. Who are they listening to? You know what. Take this bill out to the rural areas of Nebraska. You will get an earful.

Mrs. HUTCHISON. How much time is left on our side?

The PRESIDING OFFICER. Seven seconds—2, 1, 0. Time has expired.

Mrs. HUTCHISON. Let me give the last 5 seconds to the Senator from South Dakota.

The PRESIDING OFFICER. Time has expired.

Mr. THUNE. I yield back my 5 seconds. I don't have enough time to distribute equally. It would not be fair.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Mr. President, I ask unanimous consent that the

time for debate only be extended until 2 p.m., with the time equally divided, with Senators permitted to speak for up to 10 minutes each, with no amendments in order during this time.

Mrs. HUTCHISON. Reserving the right to object, I ask the Senator from Florida, it is 10 minutes and going back and forth. It is not 30 minutes allocated per side; is that correct?

Mr. NELSON of Florida. It is back and forth.

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

The PRESIDING OFFICER. The Senator from Missouri is recognized.

Mr. BOND. Mr. President, I ask to be advised when I have used 8 of my 10 minutes.

The PRESIDING OFFICER. The Senator will be so notified.

Mr. BOND. Mr. President, small businesses are the backbone of our economy. They make up 99.7 percent of all employer firms. They employ just over half of all private sector employees. They pay 44 percent of the total U.S. private payroll. They have generated 64 percent—a majority—of the net new jobs over the past 15 years. They create more than half of the nonfarm private gross domestic product, and they hire 40 percent of all high-tech workers.

Small businesses drive this economy. They are also the sector most in need of real health reform that will reduce cost and make it easier to buy insurance. It is estimated that 26 million of the uninsured are small business owners, employees, and their dependents. That is a majority of the uninsured. They continue to struggle to be able to afford health care.

Here are two examples: Jim Henderson, president of Dynamic Sales in St. Louis, has made every adjustment in the book to continue to provide health insurance to his employees. He covered both employees and their families back in the 1980s, but he is now at a point where he can only afford to provide for his employees. He pays 70 percent, his employees 30 percent. Jim is one of the very few small businesses that right now have weathered the storm despite the economy. He wants reform that lowers cost and helps individuals better spend their health care dollars.

Unfortunately, the Democratic health care bills we have seen so far—and I guess we haven't seen all of them—won't help Jim to continue to provide his employees health care.

Kathie and Tom Veasey own True Value Hardware in Wilmington, DE, the hometown of Vice President BIDEN. They employ 28 people, most of whom they consider family. They cover 100 percent of the cost for their employees and half for their families. But they have seen huge increases in premiums over the years, with a 36-percent increase just this year after an employee got sick. Each year, they are forced to shop for health insurance, but they continue to have limited choices due to an uncompetitive market.

Unfortunately, the Democratic bills won't fix the problem or help Kathie and Tom continue to provide their employees health care.

If we really want to get out of this recession, if we really want to address the problem of affordable and accessible health insurance, then the majority party needs to take a hard look at health care reform.

First of all, we need to allow small businesses to go together and purchase health care across State lines so they have true competition and so they can lower costs. We need medical malpractice reform, which would cut $120 billion to $200 billion out of the cost of health care.

However, when we look closely, the bills we see before us do not address the real health care needs, and, in fact, by imposing more taxes—and taxes which the CBO said will be passed from health care companies down to those who are paying the private bills—not only will it make health care less affordable for these small businesses, it will force many of them to drop whatever coverage they have now.

Tax equity is extremely important. An employee of a large corporation or a union member who gets health care premiums paid for by their employer or by their union doesn't have to record them as income. Small businesses, their employees, farmers, and individual purchasers need the same benefit that the employees of large corporations and union members get.

Now, instead of proposing commonsense health care solutions for small businesses, the bills we have seen coming out of the smoke-filled rooms run by the majority leader continue to heap costly new burdens on small businesses that are trying to keep their doors open. More and more it seems small businesses are under attack, and that is what they are telling us. One of the universities that visited me this past week is trying to do something to help small businesses, and I said: What is the attitude? They say: The attitude of small business is that they are under attack by what is being done in Congress and what is being proposed by the administration.

The 2010 budget calls for tax increases on those earning $250,000 or more. For small businesses that are taxed at their personal rate—proprietorships, partnerships, and sub S corporations—these tax increases hit the returns of those small businesses, and they are taxed at the punitive rate. Higher energy taxes on businesses in the cap-and-trade plan will put many small businesses in my part of the country out of work. New taxes and new mandates in the health care bill will be passed on.

Randy Angst of Lebanon, MO, says the following about the Senate bill:

> The new taxes would eliminate roughly half of my profits. It would force me to let employees go, refrain from hiring new employees and prevent me from reinvesting in my business. The mandates would be very harmful and make it much more costly for me to operate my business.

This bill—the last bill we have seen—requires a costly $28 billion new mandate on businesses that do not offer health care. Who pays that mandate? Anybody looking for a job. If you tell businesses they have to spend big money on a mandate, they cannot spend it on hiring new workers. The mandates do nothing to reduce insurance costs, and because they are focused on full-time workers, the mandate gives companies an incentive to classify more of their workers as part time.

Gene Schwartz, with K&S Wire Products in Neosho, MO, says:

> We are in a recession and I am in manufacturing. The legislation would be nothing but detrimental to us. Our workforce is already down 25 percent from last year, and if this bill goes through in its current form, the new taxes and mandates will force me to make further cuts. Also, this bill will increase my costs by further raising my already sky-high insurance premiums.

This bill also includes more paperwork which is costly for a small business. Section 9006 requires that every time a business vendor sells a service or property exceeding $600 to another business, the receiving business must report the transaction to the IRS. That is an enormous new costly paperwork burden that will hit almost every business regardless of how small.

These mandates and regulations disproportionately affect small businesses and come at a high cost. According to the SBA's own Web site, very small firms with fewer than 20 employees annually spend 45 percent more per employee than larger firms to comply with Federal regulations. These very small firms spend 4½ times as much per employee to comply with environmental regulations and 67 percent more per employee on tax compliance than their larger counterparts.

The bill clearly fails to bring down the cost of health care for small businesses. It fails to bring down the cost of health care at all, but it is especially hard on small businesses that can't afford coverage under the current law.

Small business owners from my State have come to me for two decades looking for more affordable ways to make health insurance available. They want to be able to provide insurance for their people. That is why I have long been a champion of small business health care reform.

Does the majority's bill include strong reform that will allow small businesses and the self employed access to more affordable, more accessible health care? No.

Does the bill include protections for small businesses that disproportionately feel the burden of increased government mandates and taxes? No.

In fact, CBO has said that this bill will increase premiums for individuals in the non group market by 10–13 percent.

Premiums for small businesses could increase by 1 percent or be reduced by 2 percent but it is easy math. If a small business cannot afford to provide health insurance now, they will not be able to afford to do so under this bill.

According to CBO, under current law families in a small group plan today pay about $13,300. In 2016, they will pay about $19,200 if this bill becomes law.

That is the wrong direction.

Health care is already too expensive for small businesses. We need to make it cheaper. It should not cost a family $19,200 in 2016 for health insurance.

This bill continues down the path of unsustainable health care costs.

In fact that is one of the main reasons the National Federation of Independent Businesses opposes this bill. They say, ''Small businesses can't support a proposal that does not address their number 1 problem—the unsustainable cost of healthcare. With unemployment at a 26-year high and small business owners struggling to simply keep their doors open, this kind of reform is not what we need to encourage small business to thrive.''

This bill also imposes new taxes and fees, like the $6.7 billion per year tax increase on health insurance companies.

Yes, the majority wants to sock it to the insurance companies.

Well, guess what. The insurance companies are going to pass the costs along to consumers.

Small businesses cannot self-insure, they must purchase products available in the marketplace. That is why CBO has found that increased costs due to fees being passed on to the consumer will be more pronounced for small businesses. NFIB has also said this new tax will fall almost exclusively on small businesses.

This bill just does not help small businesses.

I know the argument my colleagues on the other side offer.

They say they provide a tax credit to help small businesses.

What they don't say is that this is a bait and switch.

First of all, in order to get the full credit, you cannot have more than 10 workers who get paid an average of $20,000.

After that, the credit begins to phase out for each employee you have above 10. It also phases out for each $1,000 increase in average wages above $20,000. If you have 25 employees or you pay more than an average wage of above $40,000, you don't even get the credit.

The real kicker is that the full credit is only available for 2 years after the exchange takes effect. Then that is it.

A small business will either have to offer an employee health insurance—which will really not be any cheaper than it is today—or they will have to pay a fine. Or an employee can go into the exchange as an individual where insurance will cost 10–13 percent more.

Let us examine a realistic situation using Jim from St. Louis as an example.

As I mentioned before, the small business tax credit is filled with thresholds and variations that make it of limited value for the few small businesses that are eligible to claim the credit.

The full value of the credit, which is equal to 50 percent of the business owner's costs, is available for small businesses with 10 or fewer workers that pay their employees an average annual wage of $20,000 or less. But the credit also starts to phase out as the employer adds employees or gives raises, so the entire credit is gone if the employer has 25 or more employees and pays them an average wage of $40,000 or more.

Jim has six employees and his average annual wage is about $39,000. Jim has to ask if he meets the two threshold questions before he can determine whether he gets the tax credit. He passes the first test, since he only has six employees. But Jim's credit is reduced because he has paid his employees too much in wages.

Today, Jim's health care costs are $30,540. If he qualified for the full value of the credit, his annual health care costs would be $15,270—about half of what he pays now.

But the value of his small business tax credit is directly related to wage, so the value of Jim's credit is reduced to $763 based on the formula. That is a small fraction of his health care costs and wouldn't even cover the cost of hiring an accountant to figure out how much the credit is worth.

Because Jim is already so close to the highest average wage to be eligible for any credit at all, this means if he gives his employees a well-earned and well-deserved raise, he will lose the credit altogether.

In these tough economic times, the government is encouraging small business owners like Jim to create more jobs, but if they create too many or pay people too much, then the government will reward them by taking away their small business tax credit.

And even worse, the phase-outs mean that Jim has a disincentive to hire more workers.

So this bill completely misses the mark for small businesses.

Mr. President, our small businesses are struggling. We owe more to this critical sector of our economy which is responsible for half of the private-sector jobs and employees than a bill that mandates taxes and fails to provide real health care reform.

In a recent letter to Senator REID, the NFIB outlines how the bill will adversely affect business owners.

When evaluating healthcare reform options, small business owners ask themselves two specific questions. First, will the bill lower insurance costs? Second, will the bill increase the overall cost of doing business? If a bill increases the cost of doing business or fails to reduce insurance costs, then the bill fails to achieve their No. 1 goal—lower costs.

In both cases, the Patient Protection and Affordable Care Act (H.R. 3590) fails the small business test and, therefore, fails small business.

They further say in the letter:

Despite the inclusion of insurance market reforms in the small-group and individual marketplaces, the savings that may materialize are too small for too few and the increase in premium costs are too great for too many. Those costs, along with greater government involvement, higher taxes and new mandates that are disproportionately targeted at small business and are being used to finance H.R. 3590, create a reality that is worse than the status quo for small business.

It is worse than the status quo.

Mr. President, it is time to stop attacking small business and work on real reform. We should defeat this proposal that does not make insurance more affordable, is a massive government intrusion into health care and that will pay for new entitlement programs on the backs of our small businesses.

Let us put this debate in context. If small businesses do most of the hiring, and we are counting on them to help lead us out of the recession, why would we want to increase their costs of doing business and make it less likely they will hire new workers?

President Obama hosted a Forum on Jobs and Economic Growth last week, where he invited ideas to jump start job growth in our sluggish economy.

Now, he and the majority are considering a new plan to jump-start job growth using ''unspent'' or returned TARP funds. Have they forgotten that it is all borrowed money, and thus deficit spending, in the first place?

Let me submit that the bill before us will hurt job creation.

Before practicing medicine, doctors often take an oath, the Hippocratic Oath, where they promise to refrain from doing harm. I would like to see Congress and the President take the same oath.

How can you on the one hand legislate new taxes on businesses in the name of health reform—coupled with new energy taxes in the name of climate protection—and on the other hand ask businesses to generate new jobs? It cannot be done. Massive tax increases and job creation are mutually exclusive.

Employers who face uncertainty regarding new, oppressive taxes and mandates are not going to want to sink money into new jobs. It is that simple.

We should think about the harm we will do to small businesses through this legislation and instead work on commonsense reforms that have bipartisan support.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from the National Federation of Independent Businesses.

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

NATIONAL FEDERATION
OF INDEPENDENT BUSINESS,
December 8, 2009.

Senator HARRY REID,
Majority Leader, Hart Senate Office Building, Washington, DC.

Senator MITCH MCCONNELL,
Minority Leader, Russell Senate Office Building, Washington, DC.

DEAR SENATORS REID AND MCCONNELL: As the Senate continues to debate the future of comprehensive healthcare reform, the National Federation of Independent Business,

the nation's leading small business association, is writing in opposition to the Patient Protection and Affordable Care Act (H.R. 3590).

When evaluating healthcare reform options, small business owners ask themselves two specific questions. First, will the bill lower insurance costs? Second, will the bill increase the overall cost of doing business? If a bill increases the cost of doing business or fails to reduce insurance costs, then the bill fails to achieve their No. 1 goal—lower costs.

In both cases, the Patient Protection and Affordable Care Act (H.R. 3590) fails the small business test and, therefore, fails small business. The most recent CBO study detailing the effect that H.R. 3590 will have on insurance premiums reinforces that, despite claims by its supporters, the bill will not deliver the widely-promised help to the small business community. Instead, CBO findings report that the bill will increase non-group premiums by 10 to 13 percent and result in, at best, a 2 percent decrease for small group coverage by 2016. These findings tell small business all it needs to know—that the current bill does not do enough to reduce costs for small business owners and their employees.

Despite the inclusion of insurance market reforms in the small-group and individual marketplaces, the savings that may materialize are too small for too few and the increase in premium costs are too great for too many. Those costs, along with greater government involvement, higher taxes and new mandates that are disproportionately targeted at small business and are being used to finance H.R. 3590, create a reality that is worse than the status quo for small business. The shortcomings of the Patient Protection and Affordable Care Act include:

A New Small Business Health Insurance Tax

Unlike large businesses, which self-insure and find security under the blanket of ERISA, most small businesses are only able to find and purchase insurance in the fully-insured marketplace. The Senate bill includes a new $6.7 billion annual tax ($60.7 billion over 10 years) that falls almost exclusively on small business because the fee is assessed on the insurance companies. CBO's most recent study reinforces those costs will ultimately be passed on to their consumers, leaving the cost to be disproportionately borne by small business consumers in the individual and small-group marketplace whose only choice is to purchase those products or forgo insurance altogether.

A New Mandate That Punishes Employers, Employees and Hinders Job Creation

Employer mandates fail employers and employees in two ways. First, mandates do nothing to address the core issue facing small business—high healthcare costs. Second, mandates destroy job creation opportunities for employees. The job loss, whether through lost hiring or greater reliance on part-time employees, harms low-wage or entry-level workers the most. The employer mandate in H.R. 3590 sets up potentially troubling outcomes for this sector of the workforce. The multiple penalties assessed on full-time workers will most certainly result in a reduction of full-time workers to part-time workers and discourage the hiring of those entrants into the workforce who might qualify for a government subsidy, hardly an outcome that contributes to a greater insured population.

A Poorly-Structured Small Business Tax Credit

As structured, the small business tax credit will do little, if nothing, to propel either more firms to take-up coverage or produce greater overall affordability. Due to its short-term temporary nature and the limitations based on the business' average wage, its benefit is, at best, a temporary solution to the long-term cost and affordability problem. A tax credit that is poorly structured is not going to provide sustainable and long-term relief from high healthcare costs, and the recent CBO finding that the tax credit would benefit only 12 percent of the small business population illustrates its lack of effectiveness.

A Benefit Package That Is Too High a Hurdle for Small Business

NFIB has voiced concern over establishing a benefit threshold that is too high a price tag for small businesses to meet. Small businesses are especially price sensitive. They need purchasing choices that provide the flexibility in coverage options that reflect their marketplace and business needs. If Congress doesn't adjust the actuarial value standards in the legislation, what may be affordable this year may be unaffordable next year. As a result, small business owners will be at risk of having to drop coverage due to cost increases that outpace their healthcare budgets.

Destructive Rating Reforms and Phase-In Timelines That Threaten Affordability for All

NFIB supports balanced federal rating reforms that protect access and affordability, regardless of an individual or group's health status. However, the excessively tight age rating (3:1) in H.R. 3590 will increase more costs than it will decrease, and make coverage unaffordable for the very populations that are most beneficial to the insurance pool—the young and the healthy. Independent actuaries have analyzed the negative impact of such tight bands and have indicated that there will be devastating effects to the long-term viability of a pool without action to correct this rating imbalance.

Additionally, to prevent volatile spikes in insurance premiums, also known as ''rate shock,'' federal rating reforms must be appropriately applied to all marketplaces and phased in over a responsible period of time. If this is not done, then certain plans, including ''grandfathered plans,'' will utilize different rating practices when underwriting risk, which can create adverse selection issues. Those selection problems will have a striking negative impact on the new exchanges—exchanges that are meant to improve, rather than decrease, affordability for small business and individuals.

National Plans That Provide Limited Promise for Success

Leveling the playing field for small business starts with allowing uniform benefit packages to be purchased across state lines. If done right, this can provide a greater security that, as people change jobs and move from state to state, they can keep the benefit plan that meets their healthcare needs. National plans would be particularly helpful for states with smaller populations and where consumers lack a robust marketplace with choice and competition for private plans. Specifically, the state ''opt-out'' language in the Patient Protection and Affordable Care Act would create more disincentives than incentives for carriers to embark on these new opportunities. If the national plan section is not significantly restructured to make national plans a viable option, then these new opportunities will never materialize for small business.

Threatens Flexibility and Choice for Employers and Employees

Small employers need more affordable health insurance options and new alternatives for employers to voluntarily contribute to individually-owned plans. Provisions also need to be structured to insure that options are widely available to both employers and employees. The simple cafeteria plan language in H.R. 3590 excludes the owners of many ''pass-through'' business entities from participating in these arrangements. If owners are unable to participate in the plan, they will be less likely to provide insurance to their workforce. Finally, small business needs the freedom and flexibility to preserve options that are already proven to work. Prohibiting the use of HSA, FSA and HRA funds to purchase over-the-counter medications, along with the $2,500 limit on FSA contributions, diminishes that flexibility and threatens to further limit the options employers have to provide meaningful healthcare to their employees.

New Paperwork Costs on Small Businesses

The cost associated with tax paperwork is the most expensive paperwork burden that the federal government imposes on small business owners. The Senate bill dramatically increases that cost with a new reporting requirement that is levied on business transactions of more than $600 annually, leaving small business buried in paperwork and increasing their paperwork compliance expenses.

An Unprecedented New Payroll Tax on Small Employers

Since its creation the payroll taxes that fund the Medicare programs have not been wage-based and are dedicated specifically to funding Medicare. The Senate bill changes the nature of the tax and creates a precedent to use payroll taxes to pay for non-Medicare programs.

The Absence of Real Medical Liability Reform

NFIB strongly supports medical liability reform as a means to both inject more fairness into the medical malpractice legal system, and to reduce unnecessary litigation and legal costs. Taking serious steps to adopt meaningful medical liability reform is a significant step toward restoring common sense to our medical liability litigation system. It also is especially critical to improving access to healthcare for those living in rural areas, where it is becoming increasingly difficult for those in need to locate specialists such as OB/GYNs and surgeons.

The Creation of a New Government-Run Healthcare Program

A government-run plan will drive the private healthcare marketplace out of business. Private insurers will be unable to compete in a climate where the rules and practices are tilted in favor of a massive government-run plan. This means millions could lose their current coverage. This will decrease choice and increase costs. On both accounts, the government-run plan will leave small business with a single option—the government-run plan, which is the exact opposite outcome small businesses want from healthcare reform.

There is near universal agreement that, if done right, small business has much to gain from healthcare reform. But if it is done wrong, then small business will have the most to lose. The Patient Protection and Affordable Care Act, which is short on savings and long on costs, is the wrong reform, at the wrong time and will increase healthcare costs and the cost of doing business. NFIB remains committed to healthcare reform, and urges the Senate to develop common sense solutions to lower healthcare costs while ensuring that policies empower small

business with the ability to make the investments necessary to move our economy forward.

Sincerely,

SUSAN ECKERLY,
Senior Vice President,
Public Policy.

Mr. BOND. Mr. President, I have a couple of other comments I wish to add.

We have now learned that there is a new proposal coming out of the back rooms—the smoke-filled rooms. Every time something new is thrown up on the wall, we stand around with a great deal of interest to see whether it sticks. When you look at this one, I don't believe it sticks. I think it stinks.

If you read the Washington Post's lead editorial today, its headline is ''Medicare sausage? The emerging buy-in proposal could have costly unintended consequences.''

Mr. President, I ask unanimous consent to have printed in the RECORD, after my remarks, the Washington Post article.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). Without objection, it is so ordered.

(See exhibit 1.)

Mr. BOND. At the end of the article, it says:

> The irony of this late-breaking Medicare proposal is that it could be a bigger step toward a single-payer system than the milquetoast public option plans rejected by Senate moderates as too disruptive of the private market.

To say that it moves toward a public takeover is confirmed by one of the most outspoken backers of the public option, the one most interested in getting public control or governmental control of all of health care, New York Representative ANTHONY WEINER. He is quoted in Politico today as having hailed the expansion of Medicare as an unvarnished triumph for Democrats like himself who have been pushing for a single-payer run health care system. In the article, he says: ''Never mind the camel's nose, we've got his head and his neck in the tent.''

I think that is clear. Trying to expand Medicare will almost assuredly drive all the private plans out of the market. Why? Medicare pays 80 percent of the cost of hospitals and less for doctors, and they have to make up the rest of their cost by charging privately covered patients more money. It will raise the cost so that private health care can no longer succeed.

EXHIBIT 1

[From the Washington Post, Dec. 10, 2009]

MEDICARE SAUSAGE?

The only thing more unsettling than watching legislative sausage being made is watching it being made on the fly. The 11th-hour ''compromise'' on health-care reform and the public option supposedly includes an expansion of Medicare to let people ages 55 to 64 buy into the program. This is an idea dating to at least the Clinton administration, and Senate Finance Committee Chairman Max Baucus (D-Mont.) originally proposed allowing the buy-in as a temporary measure before the new insurance exchanges get underway. However, the last-minute introduction of this idea within the broader context of health reform raises numerous questions—not least of which is whether this proposal is a far more dramatic step toward a single-payer system than lawmakers on either side realize.

The details of how the buy-in would work are still sketchy and still being fleshed out, but the basic notion is that uninsured individuals 55 to 64 who would be eligible to participate in the newly created insurance exchanges could choose instead to purchase coverage through Medicare. In theory, this would not add to Medicare costs because the coverage would have to be paid for—either out of pocket or with the subsidies that would be provided to those at lower income levels to purchase insurance on the exchanges. The notion is that, because Medicare pays lower rates to health-care providers than do private insurers, the coverage would tend to cost less than a private plan. The complication is understanding what effect the buy-in option would have on the new insurance exchanges and, more important, on the larger health-care system.

Currently, Medicare benefits are less generous in significant ways than the plans to be offered on the exchanges. For instance, there is no cap on out-of-pocket expenses. So would near-seniors who buy in to Medicare get Medicare-level benefits? If so, who would tend to purchase that coverage? Sicker near-seniors might be better off purchasing private insurance on the an exchange. But the educated guessing—and that's a generous description—is that sicker near-seniors might tend to place more trust in a government-run program; they might assume, with good reason, that the government will be more accommodating in approving treatments, and they might flock to Medicare. That would raise premium costs and, correspondingly, the pressure to dip into federal funds for extra help.

In addition, the insurance exchanges proposal is being increasingly sliced and diced in ways that could narrow its effectiveness. Remember, the overall concept is to group together enough people to spread the risk and obtain better rates. But so-called ''young invincibles''—the under-30 crowd—would already be allowed to opt out of the regular exchange plans and purchase high-deductible catastrophic coverage. Those with incomes under 133 percent of the poverty level would be covered by Medicaid. The exchanges risk becoming less effective the more they are Balkanized this way.

Presumably, the expanded Medicare program would pay Medicare rates to providers, raising the question of the spillover effects on a health-care system already stressed by a dramatic expansion of Medicaid. Will providers cut costs—or will they shift them to private insurers, driving up premiums? Will they stop taking Medicare patients or go to Congress demanding higher rates? Once 55-year-olds are in, they are not likely to be kicked out, and the pressure will be on to expand the program to make more people eligible. The irony of this late-breaking Medicare proposal is that it could be a bigger step toward a single-payer system than the milquetoast public option plans rejected by Senate moderates as too disruptive of the private market.

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

Mr. BOND. I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, over the past several months, I have come to the floor of this body many times to speak about the urgent need for comprehensive health care reform. I have said that our bill must accomplish three goals in order to be effective: It must bring competition to the insurance market—competition to the insurance market—it must provide significant cost savings to ordinary Americans, and it must restore accountability to an industry that has run roughshod over the American public for far too long. I would like to focus on this last point with my remarks today.

We need real accountability in the insurance market. After almost 100 years of debate about health care reform, this Senate stands on the verge of making history. There are many good elements in the legislation that is before us today, but without accountability, any reform measure would be toothless and inconsequential. If we don't give the American people a chance to hold their insurance providers accountable, quality care will continue to elude certain segments of our population. We can't stand for this any longer. We must prevent insurance companies from discriminating against people by charging them higher rates or denying coverage because of certain conditions.

Everyone knows it is hard for uninsured patients to get quality medical care. Under the current law, in the case of catastrophic injury or illness, anyone admitted to the emergency room should receive equal treatment to save their life. Shockingly, Harvard researchers have found that this is not the case. They examined 690,000 individual cases over 4 years and found that uninsured patients are nearly twice as likely to die in the hospital as patients with similar injuries who do have insurance. And even after these results were adjusted to account for age, race, gender, and the severity of the injuries, they found that the uninsured were still 80 percent more likely to die than those with health coverage, including Medicaid.

I just had a delegation of physicians in my office. I listened to their comments in reference to wanting us to make sure we passed a health care reform bill this session. One of those physicians began to relate to me the story of his brother, who was employed but was without health insurance. At 41 years old, he died of cancer because he waited too long to try to get treatment. And because he was uninsured and no one would treat him, that took his life at the young, tender age of 41.

So this new evidence is conclusive, and it is truly disturbing. The poor and the uninsured suffer disproportionately under our current system. In the most advanced country on Earth, there is no excuse for this stunning inequality.

Big corporations know there is a lot of money to be made out of the poor and they do not hesitate to rake in large profits and their expenses. These companies exploit minor technicalities

to deny coverage to people who are sick. They use gaping holes in the system to refuse treatment for those with certain conditions. That is because they do not see patients as real people who need help, they see them as numbers in the corporate ledger. They see risk and expenses and lower dividends for their shareholders. That is why we need to prioritize patients over profits. That is why we need to extend coverage to more people and make these companies accountable for the first time in decades.

If we pass insurance reform with a strong public option it would be illegal to deny coverage because of a preexisting condition. For the first time in many years, ordinary Americans would be able to shop around if they are paying too much, or they are not being treated fairly. Costs would come down, coverage would improve, and lives would be saved.

Let us pledge ourselves to this cause. Let us make sure every American can get the treatment they need in the emergency room regardless of their income, need, or the insurance coverage they have. We must not fall short in this regard. We must not settle for anything less.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, my friends on the other side of the aisle have consistently stated that this 2074-page Reid bill, according to the Joint Committee on Taxation, is a net tax cut. I want to put emphasis throughout my remarks on the word ''net.''

Yesterday a chart was used to illustrate this point. This chart had multiple bars with dollar figures. For example, in 2019 the chart showed a $40.8 billion net tax cut. My Democratic friends said this number came from the Joint Committee on Taxation, a very responsible, intellectually honest group.

Unfortunately, the chart my friends were using was not entirely clear on how they came up with this net tax cut for Americans. So it was natural for most of the fellow Senators and the country at large to wonder how my Democratic friends got this number. They said show me the data.

To clear up any confusion, right here is the Joint Committee on Taxation table that the Democrats relied on to claim that the Reid bill results in a net tax cut. Here it is. We can see the negative $40,786, for example. That is the figure that was used. As the chart indicates, these dollar amounts are in the millions, so $40,786 million. The Joint Committee on Taxation says it this way: This means negative—the negative mark there—negative $40.8 billion.

My friends on the other side unfortunately did not explain what was going on here. It appears my friends simply made an assertion that they hoped many of us and those in the media would believe. But I cannot let my Democratic friends get off the hook this easily. Why? Because the entire story is not being told, so let me take a moment to explain.

First, in simplest terms, where you see negative numbers on this chart, the Joint Committee on Taxation is telling us there is some type of tax benefit going to the taxpayers. So this group and these groups here, wherever there is a negative here, those are tax benefits to the benefit of the taxpayers.

For example, families making $50,000 to $75,000 have a negative of $10,489 in their column. This means the Joint Committee on Taxation is telling us that this income category is receiving $10.4 billion in tax benefits.

I hope you will listen closely. When we see a negative number on this chart, the Joint Committee on Taxation tells us there is a tax benefit so, conversely, where we see a positive number the Joint Committee on Taxation is telling us that these taxpayers are seeing a tax increase. I have actually enlarged those numbers, the number of tax returns and the dollar amounts where there is a positive number for individuals and families. Again, these positive numbers indicate tax increase.

My friends have said that all tax returns in this chart are receiving a net tax cut. If that were so, why aren't there negative numbers next to all of the dollar amounts listed? Because not everyone in this chart is receiving a tax cut, despite what my friends have said. Quite to the contrary, a group of taxpayers is clearly seeing a tax increase and this group of taxpayers in middle income is seeing tax increases.

I didn't come down to the floor to say my friends on the other side of the aisle are wrong. After all, you can see here the negative $40,786 million figure they used is right there, out in the open. What I am doing is clarifying that my Democratic friends cannot spread this $40.8 billion tax cut across all the affected taxpayers on this chart, and then say that all have received a tax cut.

You want to know why. Because this chart, produced by the nonpartisan Joint Committee on Taxation, shows that taxes go up for those making more than $50,000 and families making more than $75,000. It is right here in the yellow, as you can see.

The numbers obviously do not lie. I say the nonpartisan Joint Committee on Taxation, I think everybody agrees, is very intellectually honest. So let me give you my read on what the Joint Committee on Taxation is saying here as evidenced by the figures on the chart.

First, there is a group of low- and middle-income taxpayers who clearly benefits under the 2074-page bill that is before the Senate. They benefit from the government subsidy of health insurance. This group, however, is relatively small.

There is another much larger group of middle-income taxpayers who are seeing their taxes go up due to one or a combination of the following tax increases: the high-cost plan tax increase, which actually is a brandnew tax; the medical expense deduction limitation, which used to be 7.5 percent, and now before you can deduct you have to have 10 percent of your income be medical expenses or you don't deduct anything, so that is a tax increase; and then a Medicare payroll tax increase, where everybody is going to pay—well, everybody over a certain income is going to pay an additional half a percentage point or, if you are self-employed, pay 1 percent more of payroll tax. In general, this group is not benefiting from the government subsidy. After all, how can a taxpayer see a tax cut if they are not even eligible for the subsidy?

Also, there is an additional group of taxpayers who would be affected by other tax increase provisions in the Reid bill that the Joint Committee on Taxation could not distribute in the way people are distributed on this chart. These undistributed tax increases include, among others, the cap on Federal savings—flexible savings accounts. Then there is a tax on cosmetic surgery.

My friend from Idaho, the author of the amendment before us, Mr. CRAPO, recently received a letter from the Joint Committee on Taxation stating that this additional group exists and many in this group will make less than $250,000 and, hence, have a tax increase that is not accounted for here and also a tax increase if they are under $250,000. That is a violation of the President's promise in the last campaign that nobody under that figure would get a tax increase—only people over $250,000.

So you see, my Democratic friends cannot, No. 1, say that all taxpayers receive a tax cut—I have proven that here—and, No. 2, say that middle-income Americans will not see a tax increase under the Reid bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, some of the charges from the other side of the aisle have taken us down some detours to essentially try to distract us from some of the main points of this legislation. I want to take a few moments to discuss one of the key features of the bill and that is insurance market reform.

The bill would change the way insurance companies do business in America. Sometimes I think this reform is part of the reason some on the other side are fighting this bill so hard. Our bill will end the practice, widespread today, of insurance companies denying coverage altogether, or charging someone an exorbitant amount of money if they have some preexisting condition, something in their health history which is an issue. Our bill would make those changes right away. They start going into effect in 2010. That is, the prohibition on companies denying coverage for preexisting conditions or

health care stats, and right down the list, would take effect right away, 2010.

We all have countless numbers of examples, either directly or through friends or relatives of small insurance companies that either denied insurance coverage or you have to pay much greater increase in premiums because of a preexisting condition, whatever it may be, of something. It is wrong, flat, outright, 100 percent wrong. This bill stops that, stops those practices by insurance companies.

I think it is important that we not get sidetracked by some other very important matters but keep focused on what this legislation does. It reforms the health insurance industry.

What else does our bill do with respect to reforming the health insurance industry? It would prohibit lifetime limits on payments to people who get sick. Right now, insurance companies limit how much they pay out to people when they get sick. They have lifetime limits, annual limits. No matter how sick you are, some catastrophic coverage you have, the insurance company says: Sorry, we are putting a limit on it. That is not right. Sometimes people have conditions that require a lot more attention, more hospitalization, more attention by doctors. Our legislation would prohibit lifetime limits on payments to people who get sick.

Our bill also prohibits unreasonable annual limits. These are limits that insurance companies impose on policyholders. This reform would apply in both the group market and the individual market. What does that mean, that gobbledygook. It implies that for everybody, whether you are an individual or whether you are working for a company, this would take effect 6 months after enactment. That is pretty important. A lot of people have insurance policies with limits, where the insurance company will only pay so much to an individual or during the person's lifetime or in any year. It is not right because some conditions require a significant increase in payments or coverage for the person.

Our bill would require any insurance plan that provides dependent coverage for children to continue to make that coverage available until the child turns age 26. We know that is a problem today. Often, in a State, once a child turns 21 or 22, that person can't find health insurance. In today's economic recession, with unemployment so high, it is kind of hard for kids to find jobs, and that is how they would otherwise get their health insurance. We say family coverage covers your child until the child turns age 26. This reform would take effect 6 months after enactment.

In addition, when the exchanges are up and running, our bill would prohibit insurance companies from discriminating against consumers because of health status, generally. Sometimes the insurance industry says it is not a preexisting condition, but you have not been healthy lately so we will not give you insurance. No longer can insurance companies refuse to sell or renew policies because a person gets sick. If you pay your premiums, the insurance company has to renew your coverage.

When the exchanges are up and running, the legislation before us today would limit the ability of insurance companies to charge people much more just because of their age. That is what they do today. Sometimes, depending upon the State, the insurance company is able to charge somebody much more for the same coverage because of that person's age. Right now it is not at all unusual for insurance companies to charge more than five times as much just because a person is, say, age 55. Our bill would prohibit insurance companies from charging more than three times as much because of age. In some States, there is no limit whatsoever. In my State of Montana, we have no limit. Some States have five. We are saying down to three.

When the exchanges are up and running, our bill would prohibit insurance companies from charging women more than men. Think of that. Some insurance companies charge women more than men. That is not right. This is also a widespread practice among insurance companies that is charging women more than men. It is just plain wrong. Our legislation would stop that.

Health insurance reform also means real insurance market reform. It means real change in the way insurance companies do business. No longer will insurance companies be able to build their business by cherry-picking only the healthiest and the youngest. That is what they do today, especially for individuals, to some degree, in smaller organizations. No longer will they be able to insure only those who don't need insurance. We bring real reform. It would make insurance much more fair, and that is literally a matter of life and death.

As a recent Harvard study reported, people without insurance are 40 percent more likely to die prematurely than people with private insurance. Think of that. People without insurance are 40 percent more likely to die prematurely than people with private insurance. Tens of thousands of Americans die each and every year because they do not have insurance. Is that America? That doesn't sound like the United States we are all so proud of, where we allow tens of thousands of Americans to die each and every year simply because we have not set up a system for them to have health insurance. That is something we stop in this bill.

I suggest the absence of a quorum and ask unanimous consent that the time be charged equally against both sides.

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

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. GRASSLEY. Mr. President, I have said, for the last 2 days, I was going to speak on the Dorgan amendment, a bipartisan amendment to allow the importation of drugs into the United States. I haven't done it until now, so I am glad to rise in support of this bipartisan amendment to add provisions of the Pharmaceutical Market Access and Drug Safety Act to this bill. That legislation is the result of a collaborative effort by Senators DORGAN, SNOWE, MCCAIN, and this Senator to finally make drug importation legal.

I have, for a long time, been a proponent of drug reimportation. In 2000, 2002, and 2003, I supported an amendment permitting the importation of prescription drugs into the United States from one country, Canada. This amendment is much broader than only Canada.

In 2004, the late Senator Kennedy and I worked together on a bill that would authorize drug importation, but it did not survive the partisan politics of this Chamber. I then introduced my own comprehensive drug importation bill in 2004. That was S. 2307, the Reliable Entry for Medicines at Everyday Discounts Through the Importation with Effective Safeguards Act. The REMEDIES Act is what the acronym finally spells out. In 2005, I combined my bill with a proposal sponsored by Senators DORGAN and SNOWE. In 2007, we reintroduced a version of that legislation with the hope that our combined efforts would finally lower the cost of prescription drugs for all Americans. That is what we are still working together to do this very day. I thank Senator DORGAN for his leadership.

This time around, I should be confident that this effort will finally pass. Historically, Democrats claim to be champions of holding the big pharmaceutical companies accountable. Now we have a Democratic supermajority in the Congress and a Democratic President who has supported drug importation in the past. I am not as confident as maybe I should be. That is because the White House has participated in some back-room negotiations since the last time this legislation was brought before the Senate and then Senator Obama supported it. Behind closed doors, the Democratic White House found new friends in the pharmaceutical industry. Last summer, the head of the pharmaceutical lobbying group bragged that drug manufacturers had negotiated a ''rock-solid deal''—those are their words—with the present administration.

An article in the New York Times detailed the administration's deal with big drug companies. This quote comes from the New York Times:

> Foreseeing new profits from the expansion of health coverage, big drug companies are spending as much as $150 million on advertisements to support the President's plan.

But in 2008, when President Obama was campaigning for the position he now holds, he promised that:

We'll take on drug and insurance companies, hold them responsible for the prices they charge and the harm they cause.

Certainly, the President knows that a great way to hold drug companies accountable is to allow drug importation. In fact, in 2004, when he was a candidate to be a Member of this Chamber, he challenged his opponents to support drug importation. He said at that time:

I urge [my opponent] to stop siding with the drug manufacturers and put aside his opposition to the re-importation of lower-priced prescription drugs. . . .

But, unfortunately, it has been reported that during backroom negotiations at the White House, the big pharmaceutical companies have convinced the President to drop his strong support for drug importation.

The New York Times reports that:

On July 7—

Meaning this year—

Rham Emanuel, [President] Obama's chief of staff . . . assured at least five pharmaceutical companies during a White House meeting that there would be no provision in the final health care package to allow the re-importation of cheaper drugs. . . .

I thought we were going to hold drug companies accountable. I thought health care reform was supposed to drive down the cost of health care, including the cost of prescription drugs for all Americans. The Dorgan amendment is a commonsense, bipartisan approach to achieve both of these goals. Drug importation achieves these goals without imposing arbitrary fees, and without flexing the muscles of the Federal Government.

I have always considered this a free trade issue. I know most people see it as a health issue, and it is a health issue. But I come at it from the point of view that there are only a couple items Americans cannot buy in this country from anyplace else in the world they want to buy it. One class is pharmaceutical drugs, the other class is Cuban——

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent for 4 additional minutes and that it come off the next block of time from our side.

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

Mr. GRASSLEY. So I see this as a free-trade issue. Imports create competition and keep domestic industry more responsive to consumers. In the United States, we import everything consumers want. So I ask again, why not pharmaceuticals? That is why it is a trade issue for me as much as a health issue. Consumers in the United States pay far more for prescription drugs than those in other countries. If Americans could legally and safely access prescription drugs outside the United States, then drug companies would be forced to reevaluate their pricing strategies. They would no longer be able to gouge American consumers by making them pay more than their fair share for research and development.

It is true that pharmaceutical companies do not like the idea of opening up America to the global marketplace. They want to keep the United States closed to other markets in order to charge higher prices here.

Based on the reports I just read, it seems that the White House has already sided with the drug manufacturers and promised them the ability to continue to gouge American consumers, otherwise known as the status quo.

The debate is not over. With the Dorgan amendment, prescription drug companies will be forced to be competitive and establish fair prices in America. The drug companies will try to find loopholes in order to protect their bottom line.

The Dorgan amendment would make such action illegal. It would not allow manufacturers to discriminate against registered exporters or importers. It would prohibit drug companies from engaging in any actions to restrict, prohibit, or delay the importation of a qualifying drug.

The Dorgan amendment would give the Federal Trade Commission the authority to prevent this kind of abuse. It develops an effective and safe system that gives Americans access to lower prices. Our effort goes to great lengths to ensure the safety of imported drugs. The Dorgan amendment requires that all imported drugs be approved by the FDA. It puts in place a stringent set of safety requirements that must be met before Americans can import drugs from that country.

The amendment requires all exporting pharmacies and importing wholesalers to be registered with the FDA and inspected. It gives the authority for the FDA to inspect the entire distribution chain for imported drugs. It sets very stringent penalties for violations of the safety requirements in this bill, including criminal penalties and up to 10 years imprisonment.

We need to make sure Americans have even greater, more affordable access to innovative drugs by further opening the doors to competition in the global pharmaceutical industry.

If my colleagues on both sides of the aisle are serious about bending down the cost curve of health care inflation—and doing it in that direction, the right direction—then they will support the Dorgan amendment, a bipartisan amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Thank you, Mr. President.

I echo the comments of the senior Senator from Iowa. He is exactly right about the Dorgan amendment. There are a lot of reasons, as he pointed out, why the Dorgan amendment makes sense for the American people.

It makes sense for taxpayers because we pay way too much for prescription drugs as taxpayers. It makes sense for government programs—whether it is TRICARE, whether it is Medicare, whether it is Medicaid, whether it is the Federal Employees Health Benefits Program. It makes sense for small businesses and large businesses alike who are paying too much for prescription drugs. And it makes sense for seniors and all Americans who are paying too high a price for prescription drugs out of their pockets. It also makes sense in terms of, sort of, internationally as to what we do on the buying and selling of prescription drugs.

I was part of these discussions in the House where we had the same amendment. We would pass it, and then it would die in the Senate, or things would happen in the conference committees or whatever, where the drug companies really did exert their influence over the Congress and with the President during the Bush years.

But one of the arguments they always make is to question the safety of these drugs, that these drugs coming from Canada or these drugs coming from France are not safe, as if they did not have a food and drug administration as efficient and effective as ours in terms of protecting the public.

But what sort of shoots a hole in that argument is how many American drug companies—over and over and over, and in increasing numbers—how many American drug companies are importing ingredients especially from China.

Senator Kennedy, 1½ years or so ago, asked me to chair an oversight hearing with the Health, Education, Labor, and Pensions Committee on this issue of what is happening when these American drug companies are increasing their outsourcing of jobs, particularly to China. It was in response to what happened in Toledo, OH, among other places, where a number of Americans died because of contaminated heparin.

Heparin is a blood thinner drug that is a very important drug to keep people healthier and live longer and live better. But some of the ingredients for heparin were made in China, and the drug company is not able to trace back, if you will, the supply chain, where they are getting their ingredients. They know they get them from China. The American drug companies—whether it is Pfizer or another drug company—when they outsource their production to China, may know where the plant is that puts all these ingredients together, but they cannot trace back—or at least they will not tell us or cannot tell us—all their ingredients. So they may get this ingredient from Wuhan, and this ingredient from Shanghai, and that ingredient from a rural outpost in Hebei or Henan Province, but they cannot tell us exactly where they come from. So no wonder these drugs are not as safe as they should be.

So if they were interested in drug safety, it would not be that they would stop us from drug importation because we know if we buy it from France or Canada or Germany, they have a food and drug agency, an FDA equivalent,

that keeps their drugs safe. They know that. It is all about protecting their profits. There is simply no doubt about that. Their profits get to be bigger because they make some of these drugs in China.

So let's not have it both ways. Let's not say we cannot import drugs safely into this country—when they are exporting jobs, as so many other industries are doing, to China, exporting jobs to little villages where they manufacture these ingredients. They end up in America's medicine cabinets. Let's not talk out of both sides of our mouths, as the drug industry is doing.

A couple other comments about the underlying bill and how important it is we move on this legislation. There are more than 400 people every day—in Defiance, OH, in Gallipolis and Zanesville and Saint Clairsville and Cadiz and all over my State—400 people every single day who lose their insurance.

Every day my friends on the other side of the aisle delay, every day they offer amendments and then will not let us vote on them, and stand up and object to even voting on things, every day they try to filibuster, every day they put up another hurdle, 400 more people in my State lose their insurance. It is about 1,000 people in this country every week—1,000 people in this country every week—who die because they do not have health insurance. It is 45,000 people a year, so 900-some people every week in this country die because they do not have health insurance.

A woman with breast cancer without insurance is 40 percent more likely to die than a woman with breast cancer with insurance. I heard President Bush, in Ohio, maybe a couple years ago, say every American can get health care. They can go to an emergency room. Well, a woman suffering from breast cancer, who did not get a mammogram because she could not afford it, did not get the kinds of tests she should have because she did not have a doctor she could afford to pay, and because she did not have insurance—the emergency room does not do those kinds of things. Even if she got sick, the emergency room would not take care of her until she was almost dead. Then she could go into the emergency room and they will take care of her in her last few days or her last few weeks of life.

That is not the way we should do health care. This kind of delay, hearing these kinds of delaying actions, these kinds of delaying tactics, these kinds of ''we can't pass this,'' ''chicken little,'' ''the sky is following''—every day we have Republicans coming down here saying ''the sky is falling,'' and it simply is not.

I want this bill to be bipartisan. I am a member of the Health, Education, Labor, and Pensions Committee, as is my friend, Senator ROBERTS from Kansas, who is in the Chamber. During that markup in June and July, we passed 160 Republican amendments. Some of them were major, some of them were not so major. But this bill had a bipartisan flavor to it.

It is only on the big questions—the role of Medicare, the role of the public option—some of the bigger questions, where there are philosophical differences; the same reasons that back in the 1960s, when Medicare passed, it was passed almost only by Democrats because Republicans did not agree there should be a major role in government in our health care system.

So it is a philosophical difference. It is not so much partisan as that. So even though there are many good Republican ideas in this bill, on the big questions there is that difference.

So, Mr. President, I think it is so important—when I hear that many Ohioans, every day, lose their insurance, this many Americans, every week, die because they do not have insurance—to pass this legislation.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER. Is there objection?

Mr. BROWN. I object.

The PRESIDING OFFICER. Objection is heard.

The bill clerk continued with the call of the roll.

Mr. ROBERTS. Parliamentary inquiry, Mr. President.

The PRESIDING OFFICER. The Senator is advised the Senate is in a quorum call.

Mr. ROBERTS. I will try it again. I thought it was worked out.

I ask unanimous consent for the second time that the order for the quorum call be rescinded so I may be—

The PRESIDING OFFICER. Is there objection?

Mr. ROBERTS. So I may proceed for 15 minutes.

Ms. CANTWELL. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. ROBERTS. Is this a bipartisan objection, I would ask the Presiding Officer?

The bill clerk continued with the call of the roll.

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

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

Mr. DODD. Mr. President, I ask unanimous consent that over the next 30 minutes, the time be equally divided with 15 minutes for the majority and 15 minutes for the minority for debate purposes only.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Kansas is recognized.

Mr. ROBERTS. I thank the President. I rise today to talk about health care in general and the latest proposal to come out in the form of the so-called compromise, if there is no objection. I wish to talk about the latest proposal to come out from what some of us have determined is the majority leader's behind-closed-doors effort for the compromise on the government-run health insurance plan. I will admit very readily I do not know all of the details of this plan, although I hope to in the very near future. I think most of my friends across the aisle are in the same boat and we are all getting our information from the Post, the Times, and the rest of the catch-up media.

But this is the compromise, as I understand it: The majority leader will drop the government plan in exchange for two major policies: first, a national insurance plan run by nonprofit insurance companies and supervised by the Office of Personnel Management; and second, a massive expansion of Medicare to tens of millions of people age 55 and older.

Putting aside the first policy which, frankly, I don't understand how it could possibly work, I cannot believe anyone is seriously considering expanding Medicare as a compromise to the government-run or so-called public option. It doesn't take a genius to see that a huge expansion of Medicare is, as one single-payer advocate in the House dubbed it, ''the mother of all public plans,'' further quoting: ''An unvarnished and complete victory'' for advocates of single-payer health care and socialized medicine. That is a very strong quote, but that is the way it was.

In other words, this is not a compromise to the public option—it is worse. Maybe we need to remind ourselves why moving toward more government control of our health care system is such a bad idea. We need look no further than our current government-run insurance plans, Medicare and Medicaid, for examples. Government-run insurance plans currently control nearly half of the market. With the government's power, they have the ability to set payment levels for doctors and hospitals and home health care agencies and even hospices and all other health care providers, not based on the actual costs those providers incur when treating patients, but instead based on whatever arbitrary spending target the budget crunching bean counters determine the government can afford.

To paraphrase one observer: These types of global government budgets transform patients from sources of revenue over which providers compete to attract and serve, into sources of cost for the government to avoid, shunt off, and treat as cheaply as possible. That is not right. This has clearly been the result in the Medicare Program, often heralded as the best of all of the government's health care programs.

So to review: Medicare has been on an ever shrinking path toward bankruptcy for years. The latest reports

from the Medicare trustees say the hospital insurance trust fund will go broke within the next 8 years. The program has $38 trillion in unfunded liabilities. How has the government responded? By severely underpaying Medicare providers and denying Medicare patients' claims. Medicare only pays doctors around 80 percent of their costs, and hospitals even lower.

Privately insured Americans pay a hidden tax of nearly $90 billion a year to make up for these underpayments. But even that hasn't been enough to keep some providers in business and able to afford to accept Medicare patients. Medicaid is even worse. Medicare is also a huge denier of claims. I think many of my colleagues would be surprised to hear that Medicare denies claims more often than most private insurance companies. In fact, in 2008, Medicare had the highest percentage and the highest number of denied claims in the country. Think about that when you hear some Senators demonize private insurance companies for denying claims. Medicare is even worse.

This bill already exacerbates these Medicare problems by cutting almost $½ trillion from this already woefully underfunded program. Now we are considering adding even more people. This is a sinking ship with no lifeboats, and we are adding more folks to the deck.

By underpaying health care providers and denying claims, Medicare already rations health care. Expanding Medicare to tens of millions of new people as envisioned by this compromise we hear about will take government rationing to a whole new level. Because as the government takes over more of the health care system and becomes responsible for more of the increasing costs of that system, the only way it will be able to afford this commitment is to ration health care. As I have said countless times before, this bill gives the government all the tools it requires to ration care.

From Comparative Effectiveness Research, to the independent Medicare advisory board, to the new powers granted to the Centers for Medicare and Medicaid Services, CMS and the U.S. Preventive Services Task Force, this bill puts the rationing infrastructure into place. The U.S. Preventive Services Task Force's recent change to its guidelines pertaining to mammograms was a perfect illustration of how your health care will be rationed under this bill. For those who don't know, the task force recently reversed its longstanding advice that women should start getting regular mammograms to detect breast cancer at age 40.

Why is this important? Because under this bill, the recommendations of this task force will carry the weight of law for both government-run—i.e., Medicare—and private insurance. If the task force recommends a particular treatment or a particular set of patients, then Medicare and private insurers must cover it. If it doesn't, they don't.

What do you think will happen to treatments and tests that don't get the task force's recommendation? They simply will not be covered. That is how the government will hold down health care costs, by rationing access to treatments and tests such as mammograms.

Some government-controlled health care systems such as the one that exists in the United Kingdom are much more explicit about rationing. The rationing in this bill, quite frankly, is not as honest. Since Americans would never stand for the government explicitly rationing their health care, the authors of this bill had to come up with a pseudoscientific justification for rationing, and that justification is the main feature of this bill: Comparative Effectiveness Research, or CER.

Very generally, it is very simple. CER is the comparison of two or more treatment options to see which one is better. Sounds great, right? Except when you realize that CER is not being conducted for the purpose of improving patient care but for the purpose of saving the government money instead.

I read the CER section of the bill and I remember my amendment on CER and the distinguished chairman of the HELP Committee was very helpful, and said he would study it overnight. Because I had the word ''prohibit'' in the amendment we got into a great debate on what prohibit means. I thought it was pretty clear but, unfortunately, that was dropped from the bill, from the HELP Committee bill. We tried that again in Finance. It didn't work. We would like to try it again if we have time.

This bill establishes a CER institute to conduct this research for the purpose of justifying government rationing of health care. CER will be the golden ring of rationing.

So what we have here is a recipe for disaster: a bill that already significantly weakens the woefully underfunded Medicare Program and lays the foundation for a rationing infrastructure, plus a ''compromise'' that apparently will pour millions of more people into the program.

In the no-holds barred search for a proposal that can attract 60 votes, I don't understand how any Senator can support this idea.

This is just another Trojan horse, another incremental step toward the single-payer system. Again, as one House Member in the leadership observed:

> This gets not only the camel's nose under the tent, but his whole head and neck, too.

It is another step toward socialized medicine and increased government rationing of health care.

The American Hospital Association, American Medical Association, and the Federation of American Hospitals are finally taking notice of the advice they are receiving from their State and local hospitals and doctors. They, finally, have seen the light and have come out in opposition to this deal at least.

I urge my friends across the aisle to resist this latest misguided attempt at deal making. The consequences are too dangerous.

There is an awful lot of cactus in this health care world. I don't think we need to sit on each and every one of them.

Before yielding back my time, I truly thank the distinguished Senator from Connecticut for his comity and allowing me to make these debate comments. I thank the acting Presiding Officer in his effort to be bipartisan.

I think we will have a sad day in this body if one side or the other gets into a situation where we do not allow people to make remarks on not only the pending bills and specifically on the general issue of health care.

Mr. DODD. If my colleague will yield, he raises an interesting point. I am going back several months. As we get older, it is hard enough to remember what happened yesterday. The Presiding Officer is on the committee, as is my colleague from Vermont. There was a debate over the word ''construed'' to prohibit. I remember that word, talking about various practices. As I recall, the compromise that was offered either by my friend and colleague from Kansas or some other member was to strike the word ''construed,'' so nothing would be prohibited. I still, to this day, am not quite sure why we should not accept language that eliminates the word ''construed.'' That went on for about a day back and forth. I invite my colleague, again, to maybe get our staffs together and talk about that. I don't think he is wrong about this. I think it is good to have best practices. If a physician and patient decide, as a certainty, it is essential for that patient, then you should not be prohibited from doing that. As I recall, the debate was over the word ''construed.'' I don't want to take time from the Senator from Vermont.

Mr. ROBERTS. Mr. President, I agree with the Senator. I point out that in the specifics of the bill, I think it says shall not, in regard to cost containment on Medicare A and B, but the rest is encouraged. That is where we get into problems because CER is the blueprint on how we allot health care dollars in this country.

I might mention to the Senator, I had a chart on what CER recommended, and it had a figure of a humpback whale and how much money we would be devoting to different age groups. If you are 60—and, by the way, the average age of the Senate is 62—you are out of luck. If you are 70, you better get something fixed real quickly before this bill passes. That is my point. I thank the Senator for his comments.

Mr. DODD. Mr. President, I thank Senator ROBERTS for his amendment in the HELP Committee to protect patients by preventing rationing of health care. That is in the Senate bill. That was language we adopted, I say to my friend from Vermont. It was a Roberts amendment that was adopted in

our markup that prohibits any rationing of health care in our bill. I thank him for that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. SANDERS. Mr. President, when Republicans controlled the White House, the Senate, and the House, they had the opportunity to do something about the health care disaster in America. From 2000 to 2008, some 7 million Americans lost their health insurance. Where were the Republicans? During that same period, health care costs soared in America. Small businesspeople found themselves unable to provide health care to their workers.

Where were our Republican friends? I am delighted they are down on the floor every single day criticizing an effort to try to improve the situation. But it might have been a little better if they were here 8 years ago, bringing forth their ideas. But they were not.

Having said that, let me suggest that in the midst of this health care crisis, in which 46 million Americans have no health insurance and health care costs are soaring and, as the President indicates, that will double in 8 years if we do nothing, at a time when 45,000 Americans this year will die because they don't get to a doctor when they should, when close to 1 million Americans are going to go bankrupt from medically related bills, we need real health care reform.

That is something that I, and I know many other Members in Congress, have been fighting for for years. More than anything, I wish to see us pass strong health care reform. I must express a disagreement with some of my colleagues on the Democratic side, who think we are on the 2-yard line, we are almost there. I don't think so. I think there are a number of problems that remain in this legislation that have to be resolved. I wish to touch on a few of them.

One of the parts of this legislation is that, finally, we are going to add some 30 million Americans to health care insurance. That is a good thing. About half of them will be added to an expanded Medicaid—a huge expansion of Medicaid. But here is my concern. Right now, our primary health care system is extremely weak. Everybody knows we don't have enough primary health care doctors. We know that Medicaid, today, is on wobbly legs as it tries to take care of the people who access that program. I am not quite sure how you add 15 million more people to Medicaid if you don't have a primary health care infrastructure to accommodate their needs.

In this regard, I have fought very hard for authorization language in the Senate to greatly expand community health centers and the National Health Service Corps, for which we will train and make sure that we have the primary health care doctors, dentists, and nurses we need, desperately need.

In the House bill, there is language introduced by Representative CLYBURN, supported by the Democratic leadership, that would provide $14 billion over a 5-year period to expand community health centers, enable tens of millions more to access health care, and make sure we have the primary health care doctors and dentists we need.

It would be a cruel hoax to tell people they now have health insurance—Medicaid or another program—but not create a situation by which they can get into the doctor's office. I fear that may happen. I am going to fight as hard as I can to make sure we have the primary health care infrastructure we need. That means, in the Senate, adopting the language that currently exists in the House bill for $14 billion over a 5-year period—money which, according to a variety of studies, will pay for itself as we keep people out of the emergency room and keep people from getting sicker than they otherwise should be and ending up in a hospital. This makes a lot of sense. Community health centers have had wide bipartisan support. We have to support the House language.

On another issue, I found it interesting that my friend from Kansas, a moment ago, was denouncing the United Kingdom's health care system, denouncing socialized medicine, single payer. Well, I got a little confused by my Republican friends, who have been in Congress, saying: We love Medicare. My word, do we love Medicare. We are very angry that those Democrats are trying to cut back on that.

Republicans who, year after year, wanted to privatize Medicare, this week they love it. If they love it so much, why don't they join us in trying to expand Medicare and address some of the problems in Medicare? Let's work together.

Last week, we were criticized, but now, I guess, the tune has changed a little. Get your act together, my Republican friends. Either you continue the line you have had for many years about detesting Medicare because it is a single-payer health care program, a government health care program—that is what it is, a single-payer government health care program. You have been on the floor defending it all week long, until a couple days ago.

I support Medicare. In fact, what I believe and am fighting for is a Medicare-for-all, single-payer program because, at the end of the day, I disagree with many on this side of the aisle. I think, at the end of the day, the only way you are going to provide comprehensive universal health care to all Americans, in a cost-effective manner, is through a Medicare-for-all, single-payer system, which ends the hundreds of billions of dollars of bureaucracy and waste engendered by the private insurance companies.

One of my concerns, as we seem to be hurtling down the finish line, is I don't know who is going to be able to offer amendments. I have an amendment that speaks to what millions of Americans want, including the Physicians for a National Health Program—17,000 doctors, mostly primary health care doctors but not exclusively. They want to see this country have a Medicare-for-all, single-payer system. I understand I am not going to get very many Republicans supporting that amendment—or any Republicans. I also understand I will get few enough Democrats supporting that amendment. In the years to come, we are going to have a Medicare-for-all, single-payer system. I want that debate on the floor of the Senate. I have offered an amendment and I want to have that debated. I don't need 20 hours or 5 days. I would love to discuss that issue with my Republican friends.

Democrats, I think it is an amendment that has a right to be offered and it should be. I understand that will not pass. I will tell you what could pass and what could have Republican support, it is the provision I have been working on that at least says that in our Federalist system, where each State learns from other States, at least give States the option. If the Governor or the legislature wants to go forward with a single-payer model; maybe it works, maybe it doesn't work. I have the feeling if one State—whether it is Vermont, California, Pennsylvania, States that have strong single-payer movements, a lot of support for that concept—if one State does it well, then other States will be saying we want the same thing. It is a cost-effective way to provide comprehensive health care to all our people.

I want to touch on another issue, where I think my colleagues in the Senate are wrong and my former colleagues in the House are right. This is an issue the occupant of the chair has worked on with me. We held a press conference this morning. It is to understand this legislation is going to cost between $800 billion and $1 trillion.

How do you get the money? Well, the Senate bill contains a tax on health insurance benefits. I think that is wrong. I think that is regressive. It is called a tax on Cadillac plans. Given the soaring cost of health care in America today, what may be a Cadillac plan today will be a junk car plan 5 years from now. Millions of Americans are going to be forced to pay taxes on their health care benefits or else their employer will cut back on those benefits, and they are going to have to pay out of their own pockets. That is wrong. It is a regressive and unfortunate and unfair way to raise the revenue we need.

Our friends in the House did the right thing. They said that millionaires should be asked to pay a little bit more in taxes to make sure we expand health care coverage in this country. I support what our friends in the Senate and the House did, and I disagree with what is in the Senate bill. There will be a poll coming out this afternoon in which 70 percent of the American people, as I understand it, disagree with the tax on

health care benefits. They understand that is a tax on the middle class.

Let's be clear. We are in a terrible recession now. Working families are struggling. It is wrong for us to propose a tax on health care benefits, which in a few years will be impacting millions of middle-class workers. We should follow what the House has done and say to people at the top—millionaires who have received huge tax breaks under President Bush—that they have to pay a little bit more in taxes so we can provide health care to all our people.

There is a lot in the bill in the Senate that makes a lot of sense to me. I congratulate Senator DODD and Senator BAUCUS and all those people and their staffs who have worked so very hard on this bill. We have 31 million more people who will get insurance. There is insurance reform dealing with preexisting conditions. We made progress in disease prevention. There are a lot of good things in it.

I want to be very clear: I do not think we are at the 2-yard line. I think a lot of work has to be done to improve this bill. We need to, as I mentioned a moment ago, make major improvements in primary health care. We need to change how we fund many parts of the expansion of insurance and do away with the tax on health care benefits. We have to give States the option, the flexibility to go forward with a single-payer system if that is what they want to do.

Also, I hope very much that this afternoon we will vote and adopt the reimportation prescription drug legislation championed by Senator DORGAN. It is an absurdity in this country that we remain the country that pays by far the highest prices in the world for prescription drugs. When I was in the House, I was the first Member of Congress, as I understand it, to take Americans over the Canadian border. Back then—10, 15 years ago—women were able to purchase the breast cancer drug Tamoxifen for one-tenth the price they were forced to pay in the United States. I know the drug companies are very powerful. I know they have a lot of influence in this institution. But I hope we can do the right thing and provide affordable medicine to all Americans through reimportation. And I hope we can adopt that amendment.

I did want to say I have some very serious concerns about this legislation, and I hope they will be addressed in the coming days and weeks. I very much want to be able to vote for this bill, but I am not there now, not by any means.

I yield the floor.

Mr. WYDEN. Mr. President, at the end of the day, Americans don't care if a health reform proposal originated with a Democrat or a Republican, what matters to them is that it works. That is why I am proud to join forces with Senator COLLINS to offer commonsense amendments that will hold down premium costs and make health care more affordable for American families and their employers. As I have long said, the best way to hold down health care costs and make insurance companies accountable is to put Americans in the driver's seat and empower them to pick the plan that best fits their needs.

Along with Senator COLLINS, I am proposing as amendments to the Patient Protection and Affordable Care Act three amendments that will improve the Senate bill by doing more to hold down premium increases for all Americans while expanding health care choices for more Americans and their employers. Our amendments are as follows:

First, we are offering an amendment to provide more choices for employers and workers. While the current Senate legislation will eventually make it possible for employers to insure their workforce in the new health insurance exchanges, the legislation does not contain a mechanism to make it possible for employers to offer their workers the ability to choose any plan offered in the exchange. This Wyden-Collins amendment would correct that by making it possible for employers—who want to offer their employees the full range of choices in the exchange—to do just that while increasing competition in the new marketplace.

Under the amendment, any employer that sponsors a health plan would have the option to offer tax-free vouchers to its workers equal to the amount the employer contributes to its own health plan. Workers could then use that voucher to purchase the exchange plan that works best for them and their family. If a worker decides to purchase a less-expensive plan, the worker would keep the savings as added income just as workers wanting to purchase more generous plans in the exchange will be able to pay the additional cost out of pocket. Whatever employers pay for vouchers will remain tax deductible for employers and tax free for employees and while no employer will be required to offer vouchers under the new system, in order to encourage participation, employers who want to offer their employees tax-free vouchers will be given accelerated access to the new health insurance exchanges. Under the amendment, any employer offering its workers vouchers would have access to the exchange in 2015 rather than 2017, which is the schedule for employer access in the bill.

Our second amendment offers more choices to individuals and families in the insurance exchanges. This amendment will make it possible for individuals who are not eligible for a subsidy to purchase a catastrophic plan, regardless of age. Catastrophic plans will typically have much lower premiums than other plans offered through the exchange but subscribers will pay for most of their health care expenses out of pocket up until they exceed their plan's catastrophic limit.

Americans should have the choice to purchase more affordable coverage, if that is what works best for them. Under the Patient Protection and Affordable Care Act, individuals up to the age of 30 are eligible to purchase these plans. This Collins-Wyden amendment will extend that option to individuals—not receiving government subsidies—over the age of 30. This amendment would give consumers more choice and help ensure that more people can purchase coverage that fits their needs and is affordable to them.

The amendment includes aggressive disclosure requirements that will require catastrophic subscribers to certify that they understand the terms of the coverage and know that they are purchasing the lowest level of coverage available.

Finally, we are sponsoring an amendment to help hold down premium increases for consumers. Starting in 2010, the Patient Protection and Affordable Care Act will impose an annual fee on insurance companies based on the number of premiums written each year. This Wyden-Collins amendment will modify that fee to create an incentive for insurers to hold down rates. So, for example, insurance companies that hold down premium increases will pay lower fees, while insurers who jack up their premiums will pay much higher fees. Starting in 2010 the fee will be varied by as much as 50 percent based on how aggressively insurers control costs which will give them a strong incentive to hold the line on overhead, executive salaries, provider payments, and inefficiency. As under the bill, the total amount of the annual fee will be $6.7 billion per year.

I urge our colleagues on both sides of the aisle will support these bipartisan, commonsense amendments.

Mr. JOHNSON. Mr. President, as more American families struggle in the face of job loss and rising health care costs, the urgency with which the Senate health care debate must progress is clear.

Americans feel a growing insecurity about the future of their family and the future of our country. The recent economic crisis demonstrated the interconnectedness of Wall Street and Main Street. It confirmed what we already knew: that the strength and stability of our economy is intimately tied to the welfare of working families and our ability to direct spending down a more sustainable path.

In 2008, the United States spent $2.4 trillion on health care. By 2018, national health spending is expected to almost double, reaching $4.4 trillion and comprising 20 percent of our economy. If the growth of health care costs is not addressed, America's economy won't be able to keep up and more jobs will be lost, wages will drop, and health care benefits will be cut.

In addition to the unsustainable growth of health care costs, further faults in our current health care system leave millions of Americans one illness or job loss away from losing their health care benefits. Guaranteed access to affordable and meaningful health benefits would provide Americans with the security they deserve.

I recently heard from Brad and Joanne in Goodwin, SD. Brad is a cancer survivor and Joanne is a heart attack survivor. They had health insurance coverage at the time of their illnesses but still carry medical debt. After the economy forced the plant Joanne worked for to close in October 2008, she fell back on the health insurance coverage offered by Brad's employer. She relies on medication to manage her heart health and Brad requires regular checkups to make sure he stays cancer-free. In March of this year, the family hit hard times again when Brad's employer downsized and he was laid off.

Today, Brad and Joanne are still unable to find work and their unemployment benefits are set to run out at the end of the year. Even if they could find an insurance policy that approved them for coverage despite their pre-existing conditions, the price of health insurance in the individual market is far beyond their reach. So Joanne pays entirely out-of-pocket for her pricey heart medication and Brad can't afford to visit his doctor as often as he should. They do not know what they will do in the event they suffer another medical emergency or if their unemployment benefits run out before they are able to secure a new job.

Joanne and Brad's story illustrates the insecurity of many American families who are one job loss away from losing access to the health care they need. While South Dakota has been fortunate not to have as high of unemployment rate as other parts of the country, the economic crisis has put more and more South Dakotans on unsteady financial footing.

It is estimated that over 88 percent of South Dakotans have health insurance. This too is an impressive figure compared with other states, but it does not paint the whole picture. Nearly 61 percent of South Dakotans either purchase health insurance in the individual market or have coverage through their employer. These families are at risk of losing their coverage for reasons out of their control, such as those experienced by Brad and Joanne.

The Patient Protection and Affordable Care Act will guarantee these families access to affordable health insurance through life's ups and downs. Insurers will be barred from denying coverage for pre-existing conditions, discriminating based on gender or medical history, and will not be able to drop your coverage the moment you become ill and need costly treatment. New health insurance exchanges in every state will provide a menu of quality, affordable health insurance plans for the self-employed and those not offered coverage through their employer. Families who need assistance will be eligible for tax credits to make the plan of their choice affordable.

These commonsense solutions will give every American one less thing to worry about when they get sick, change or lose their job. As we continue to work out the details of health care reform, let us keep in mind the American families who are struggling to make ends meet in the face of job loss and rising health care costs. When we think of them, the urgency of health care reform is clear.

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

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

TRANSPORTATION, HOUSING AND URBAN DEVELOPMENT, AND RELATED AGENCIES APPROPRIATIONS ACT, 2010—CONFERENCE REPORT

Mr. REID. Mr. President, I move to proceed to the conference report to accompany H.R. 3288, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that I be allowed to proceed for a moment here prior to the vote.

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

Mr. MCCONNELL. Mr. President, I say to my good friend the majority leader, we have been anxious to have health care votes since Tuesday, and we have had the Crapo amendment pending since Tuesday. You have said repeatedly, and I agree with you, that the health care issue is extraordinarily important and that we should be dealing with it and debating it.

So it is my hope that somehow, through our discussions both on and off the floor, we can get back to a process of facilitating the offering of amendments on both sides of the aisle at the earliest possible time and we can get back to the health care bill.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I am happy to respond through the Chair to my distinguished colleague.

I think it is pretty evident to everyone here not only what has happened here on the Senate floor but the statements that have been made publicly and privately. And certainly I am not going to discuss any private conversations I have had, but based on Rush Limbaugh and Glenn Beck, which is on all the news today, they are upset at Senator MCCONNELL because he is not opposing the health care bill enough—that in a reasonable process on this, there are no efforts being made to improve this bill, only to kill this bill.

I think the debate has come to a point that I have rarely seen in the Senate. In fact, I have never seen it. To have my friends on the other side of the aisle come to the floor and in some way try to embarrass or denigrate me by virtue of the fact that—in fact, trying to embarrass me. What they should understand is that any events I had scheduled for this weekend have been canceled. Events I had last weekend had been canceled—four or five of them. To say the least, I would never, ever intentionally come to the floor and try to talk to somebody about having had a fundraiser and that is why they are trying to get out of here.

The reason I laid out to the Senate what I thought was a reasonable schedule is because, procedurally, we are where we are. The rules of the Senate are such that once cloture is invoked, that is what you stay with. I thought it would be appropriate, because we have worked pretty hard here, to have a day or two off. Anything that was reasonable, I would be happy to deal with everyone. But there was no result from this. Everything that can be done to stall and to divert attention from this bill is being done. And that is too bad, because it is important legislation.

Today, 14,000 Americans will lose their health insurance. Between now and 3:30, a number of people will die as a result of having no health insurance. So we are engaged in some important stuff; as pundits have said, some of the most important legislation that has ever been in this body.

So I am going to proceed to follow the rules of the Senate, and I am sorry we haven't been able to work with the Republicans in a constructive fashion on this health care bill, but it is obvious we haven't.

Mr. MCCONNELL. Mr. President, I ask unanimous consent to be able to respond briefly.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MCCONNELL. Mr. President, I reiterate to my good friend from Nevada, all I said was the Crapo amendment has been pending since Tuesday. We would like to vote on amendments. There has been some difficulty, apparently, in coming up with a side by side to the Crapo amendment. I understand that. But I am perplexed that it would take 2 days to come up with a side by side.

This, as has been stated by my good friend the majority leader, is the most important issue—some have said in history. It has been equated with a variety of different monumentally important pieces of legislation in American history. All we are asking is the opportunity to offer amendments and get votes. I said it in a most respectful way and meant it in a most respectful way. I think it is pretty hard to argue with a straight face that we are not trying to proceed to amend and have votes on this bill. That is what we desire to do.

The majority leader certainly has the right to move to the conference report. He has now done that—or we are about to vote on doing that. All I suggested was we would like to get back on the health care bill as soon as we can, resume the debate process on what has

been described on an issue of historic importance, and let Senators vote, which is what we do here in this body.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Mr. President, I say to my friend from Kentucky that I have an event I am going to now. I will vote and come back, and I will see if we can work something out.

The PRESIDING OFFICER. The question is on agreeing to the motion. The yeas and nays have been ordered.

The clerk will call the roll.

The assistant bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

The PRESIDING OFFICER (Ms. KLOBUCHAR). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 43, as follows:

[Rollcall Vote No. 371 Leg.]

YEAS—56

Akaka	Hagan	Nelson (NE)
Baucus	Harkin	Nelson (FL)
Begich	Inouye	Pryor
Bennet	Johnson	Reed
Bingaman	Kaufman	Reid
Boxer	Kerry	Rockefeller
Brown	Kirk	Sanders
Burris	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feinstein	Merkley	Whitehouse
Franken	Mikulski	Wyden
Gillibrand	Murray	

NAYS — 43

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bayh	Enzi	Menendez
Bennett	Feingold	Murkowski
Bond	Graham	Risch
Brownback	Grassley	Roberts
Bunning	Gregg	Sessions
Burr	Hatch	Shelby
Chambliss	Hutchison	Snowe
Coburn	Inhofe	Thune
Cochran	Isakson	Vitter
Collins	Johanns	Voinovich
Corker	Kyl	Wicker
Cornyn	LeMieux	
Crapo	Lugar	

NOT VOTING—1

Byrd

The motion was agreed to.

Mrs. BOXER. Madam President, I move to reconsider the vote.

Mr. AKAKA. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mrs. BOXER. 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. MCCAIN. 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. MCCAIN. Madam President, it is my understanding we are now on the fiscal year 2010 Consolidated Appropriations Act. I will have a lot to say about this 3,000-page omnibus appropriations bill, but I would point out to my colleagues that it is loaded down with 4,752 earmarks, totaling $3.7 billion; six bills, totaling $450 billion; 1,351 pages long, with 409 pages of earmarks. Spending on domestic programs is increased by 14 percent. Veterans spending is increased by 5 percent. That shows the priorities around here. Let me repeat that. Domestic spending programs are increased by 14 percent. Military construction and veterans spending is increased by only 5 percent.

Here we go again. Just a matter of months ago, in March, the Senate passed a monstrous $410 billion, 3,000-page omnibus appropriations bill that was loaded up with over 9,000 earmarks. At that time, those of us who complained about the ridiculous amount of waste were ignored. In fact, the President's Director of the Office of Management and Budget, Peter Orszag, said in an interview that ''this is last year's business. . . . We want to just move on''—a truly remarkable statement coming from the man the President put in charge of the government's budget.

In March, the majority leader placed the blame for the omnibus spending bill at the feet of President Bush. Senator REID said:

> . . . we have a lot of issues we need to get to after we fund the Government—something we should have done last year but we could not because of the difficulty we had working with President Bush.

So what is the excuse this time? Where will the blame be placed now? Is the majority leader having difficulty working with President Obama? We have had all year to work on 12 annual spending bills, and we only enacted 5 of them through the regular order, and 1 of those 5 was passed and sent to the President before the new fiscal year began.

We should be embarrassed by this process. Here we go again—faced with a whopping 1,350-page omnibus appropriations conference report, which contains six bills, spends $450 billion, and is loaded up with 4,752 earmarks, totaling $3.7 billion. Meanwhile, people are out of jobs, they are out of their homes, unemployment in my home State is 17 percent, and we are going to spend money on things such as $2.7 million—get this; I am not making it up—$2.7 million for supporting surgical operations in outer space—supporting surgical operations in outer space—at the University of Nebraska Medical Center, Omaha, NE; $30,000 for Woodstock Film Festival Youth Initiative; $13.9 million for fisheries in Hawaii—the list goes on and on and on and on—$200,000 to renovate and construct the Laredo Little Theatre.

We should not be spending American taxpayer dollars to replace worn auditorium seating and soundproofing materials. The list goes on and on and on: $800,000 for jazz at the Lincoln Center; $3.4 million for a rural bus program in Hawaii—you will note that Hawaii pops up all the time here—$1.6 million to build a tram between the Huntsville Botanical Garden and the Marshall Flight Center in Alabama; $750,000 for the design and fabrication of exhibits to be placed in the World Food Prize Hall of Laureates in Iowa.

I am not making these up. This is the same party and President that promised to scrub each one of these appropriations bills and get rid of the unnecessary ones.

So we will be talking a lot about this bill. But I want to point out again what is before us to the American people: six bills—not one—six bills, totaling $450 billion; 409 pages of earmarks, 4,752 earmarks, totaling $3.7 billion; and spending on domestic programs is increased by 14 percent; MILCON and veterans spending is increased by 5 percent.

I have met recently with the Governor of my State. We are suffering under incredible economic difficulties. We are having the greatest financial crisis in the history of my State. Couldn't they use some of this $3.7 billion in earmarks to pay for some of the essential services that are having to be cut back, not only in my State but all over America? No. The beat goes on. It is business as usual here in Washington.

And do not be surprised at the anger of the American people over this way of doing business—bills 1,351 pages long, filled with earmarks and pork that have nothing to do with the betterment of our Nation.

So we will be talking a lot more about many of these porkbarrel amendments that are in it. But it is awful: $200,000 for ''design and construction of the Garapan Public Market'' in the Northern Mariana Islands. We will be hearing a lot more about it.

Mr. THUNE. Will the Senator yield for a question?

Mr. MCCAIN. I will be glad to yield.

Mr. THUNE. The Senator mentioned that for these seven bills, the year-over-year increase in spending is 12 percent. Does the Senator from Arizona know what the CPI this last year was?

Mr. MCCAIN. The CPI was minus 1.3 percent, not to mention 10 percent unemployment in America, not to mention people not being able to stay in their homes, not to mention the hardest economic conditions in history, certainly, since the Great Depression.

Spending on domestic programs is increased by 14 percent. What brings that down to 12 percent is they only increased veterans spending—veterans spending—by 5 percent. But opera houses, rural bus programs, music programs—$300,000 for music programs at Carnegie Hall. Do you think Carnegie Hall needs $300,000 for music programs?

Mr. THUNE. If the Senator will yield for another question, do any of these numbers the Senator is talking about—this 12-percent increase in spending in these seven appropriations bills over

the previous year, at a time when families across this country are being asked to tighten their belts, small businesses are tightening their belts; as the Senator said, we have record unemployment—do these numbers include the almost $1 trillion that was spent earlier this year in the stimulus bill?

Mr. MCCAIN. The stimulus bill has nothing to do with that, I would say to my colleague, and we all know that. This is entirely new, six appropriations bills, totaling nearly $450 billion which, by the way, the majority leader wanted to pass by unanimous consent. Remarkable.

Mr. THUNE. I say to my colleague and friend from Arizona, that is a 12-percent year-over-year increase and the five bills that have already passed had increases that were in the teens in terms of the year-over-year increases too. I do not know how, when you pass a $1 trillion stimulus bill, much of which was distributed to Federal agencies that are also going to get these year-over-year 12-percent, 14-percent, 15-percent increases in spending, we can justify that to the American taxpayer or to hard-working Americans who are struggling right now to make ends meet and have to balance their family budgets. States are struggling to balance their budgets. But here in Washington, it seems as though it is spend, spend, spend.

Mr. MCCAIN. I would also respond to my friend, it has to be in the context of a revision over 10 years, recently, by the Office of Management and Budget from a $10 trillion to a $12 trillion deficit. The deficit for this year is $1.4 trillion, and I am not sure what it is next year. But they could not have known that in the Appropriations Committee when they passed spending measures such as this.

The point is, in the face of massive, unprecedented deficits, unfunded liabilities in Social Security and Medicare, where we are asking Americans all over to tighten their belts—in my State essential services are being cut because they do not have enough money—this is the same business as usual that we have seen for years.

I saw a poll yesterday—it was in a Hotline poll or one of those—that the approval rating of Members of Congress is below that of used car salesmen. I have not met those who express their approval. So we should not be surprised at some very interesting things that may take place in the elections coming up this November. But it is unfortunate, that is all.

Mr. THUNE. I say to the Senator, one final point I would make is, of all that spending the Senator mentioned—and again the $1 trillion in stimulus money was all borrowed money; that was all added to the debt, will be added to the debt, and is going to be paid for by our children and grandchildren, but the $1.4 trillion the Senator mentioned that last year constituted the Federal deficit means that out of every dollar the Federal Government spent last year, 43 cents was borrowed.

Mr. MCCAIN. Forty-three cents. And do you know who they borrowed it against? Our kids and our grandkids. They are the ones who are going to have to pay for it. I do not think I will. It is our kids and our grandkids whom we are laying it on. This is a colossal act of generational theft that we have committed. And believe it or not, the American people have figured it out.

Mr. THUNE. There is no question. The one thing that I guess is bothersome is most generations of Americans—your generation, obviously—worked hard, sacrificed so the next generation could have a better life. What we are basically doing is borrowing from the next generation because we have not been able to live within our means. That turns on its head one of the great ethics of America that has served this country so well for generations. Washington, DC, has not learned the lesson that when you borrow money, it has to be paid back, and that you cannot spend more than you take in. Forty-three cents out of every dollar last year was borrowed—all to be put on the bills of our children and grandchildren.

Mr. MCCAIN. The Senator is correct.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

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

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

The clerk will report the conference report.

The assistant legislative clerk read as follows:

The committee of conference on the disagreeing votes of the two Houses on 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, having met, have agreed that the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment, and the Senate agree to the same, signed by a majority of the conferees on the part of the two Houses.

(The conference report is printed in the RECORD of December 8, 2009, beginning at page H13631, Book II.)

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I know we have moved to the Omnibus appropriations bill to continue government, and the time is running out for the current authorization bill, and this brings us back to the authorization of spending, but it also takes us away from health care reform.

On this side of the aisle, we have been waiting for a long period of time to vote on some amendments that are now before the Senate, such as the Crapo motion which would send the bill back to committee to take out the tax increases that are in it. Then we also have the Dorgan amendment. I can understand why maybe the majority does not want to vote on Republican amendments, but I sure don't understand why they would object to voting on Senator DORGAN's amendment, a Democratic amendment, because there have always been more Democrats than Republicans for the Dorgan amendment, and quite frankly, I am in a position where I agree with that amendment. I am a cosponsor of it. I think we would have a great deal of bipartisan support for the Dorgan amendment. But now we are just automatically away from the health care debate and those amendments.

So I am wondering why we had to do this appropriations bill right now. I think there is growing realization that maybe public reaction, negative reaction to the legislation before us—remember that 2,074-page bill that is before us—the public is getting wise to what is in that bill and there is objection to it, and maybe now the majority party would like to have a little respite from that debate. So I thought I would come back to not the substance of the health care reform bill debate but to a lot of organizations that oppose it and why they oppose it, just to keep the public's attention that we on this side of the aisle feel the health care issue is very important.

As I travel around Iowa, I hear a lot of concern about out-of-control government spending. People are worried about all of the bailouts, the banks, and the automakers, the automakers such as General Motors being nationalized. They are worried about the rising rate of unemployment, which is 10 percent now. They don't see how we will ever dig ourselves out of the deficit hole we are in, a deficit that has been increased by $1.3 trillion since President Obama's inauguration.

As Senator MCCAIN just pointed out, the bill that has now come before the Senate to fully fund the Federal Government has 12.5-percent increases in it. From that standpoint, it seems to me we are getting away from a commonsense principle that we ought to use around here on spending, and that is that spending shouldn't eat up any more than the economic growth of the tax base that is coming into the Federal Treasury to support that spending. Quite obviously, you can't have 12.5 percent increases in appropriations this year over last year, and last year was 9 percent over the previous year. You just can't sustain that. Common sense dictates against it. But what rules here in Washington is just a lot of nonsense.

So our constituents are confused. They are confused as to why, in the face of all these fiscal problems, some in Congress are now proposing $500 billion in tax increases. Tax increases are very bad for the economy. It is more difficult to get out of the recession as

you increase expenditures. They don't understand why some are proposing the largest Medicaid expansion since the program's creation. They want to know why they are proposing $500 billion in Medicare cuts to create an entirely new entitlement program that this country can't afford.

Nowhere are these worries and this confusion more evident than among business leaders of America because business is where jobs are created. Government does not produce wealth; government consumes wealth. So if you want to expand the economy, you do it through the private sector. That is where the resources of government come from. That is where the resources that sustain our people come from.

So whether it is a small business owner on Main Street or a CEO on Wall Street, the message is clear: Stop spending, get the economy back on track, and get people back to work.

Unfortunately, the health reform bill will not address any of these goals. In fact, it may just do the opposite. Don't take my word for it. Let's take a look at what the groups that represent American businesses are saying.

Let's start with the Chamber of Commerce representing 3 million American businesses. In a press release distributed November 19, 1 day after the release of the Senate bill, the Chamber called the Senate bill a ''Missed Opportunity to Enact Meaningful Reform.'' That was their title.

Let me go to a specific quote:

> This bill still contains a government-run plan and an onerous employer mandate, it taxes working Americans, slashes Medicare, spends over a trillion dollars—and after all this—CBO tells us 24 million Americans will still not have health insurance.

That doesn't sound like the kind of reform that is going to help get the chamber members back on track hiring more workers so we can get this unemployment down. It sounds as though they will end up being forced to pay higher taxes and cut jobs. I am not an economist, but that certainly doesn't sound like a formula for getting this country out of the recession.

In fact, the chamber's press release says:

> The Chamber believes the path to a healthier economy is to cut taxes, not to raise them by $500 billion.

They go on to ask a question for which I still can't find an answer:

> Why is there still no meaningful medical liability reform? Is currying favor with the trial lawyers worth passing up $50 billion in CBO verified savings?

I think it is pretty clear that the Chamber of Commerce doesn't think this $2.5 trillion bill will cure what ails the U.S. economy.

Let's see what some other business groups have to say. The National Association of Manufacturers put out a press release the same day as the Chamber of Commerce, November 19. The National Association of Manufacturers is the Nation's largest industrial trade association. Their members build the machines that keep America running, so they should know a little bit about how to get our economy running again. Unfortunately, they see Senator REID's bill as a step in the wrong direction. Like the Chamber and like pretty much every other business group, the National Association of Manufacturers has announced that they cannot support the pending bill.

I find it hard to believe that some Senators who claim to be probusiness can support a bill that is opposed by almost the entire business community—or am I missing something? How can some Democrats who claim to want to get people back to work support a bill that economists from the far right to the far left say will reduce wages and increase unemployment? It just doesn't seem to make sense.

Like other business groups, the National Association of Manufacturers is in favor of reform. Manufacturers realize that we need health reform to lower costs, increase access, and improve quality. But according to their press release, they cannot support a bill that will—this is their quote—''add massive financial burdens to businesses that are already struggling in this recession.'' They go on to express deep concern about huge tax increases that will hurt small business manufacturers, and they are worried that both the so-called public option and the massive Medicaid expansion will just end up shifting more costs and higher premiums to private businesses.

The National Association of Manufacturers ends their press release by saying:

> Oppose the majority leader's bill and urge Senators to do the same as it raises costs and ultimately will destroy jobs.

Again, I find myself asking how someone can claim to be probusiness but support a bill that is so strongly opposed by the business community.

Let's take a look at what small businesses have to say. Maybe that is where the answer is. You have to remember that small businesses create 70 percent of the net new jobs in America. In fact, it was Christina Romer, the President's top economic adviser, who said in a recent Webcast that health care reform will ''benefit small business—not burden it.''

Unfortunately, the National Federation of Independent Businesses, the voice of small businesses, doesn't seem to agree. After the release of Senator REID's bill, the National Federation of Independent Businesses said this:

> This kind of reform is not what we need to encourage small business to thrive. We oppose the Patient Protection and Affordable Care Act due to the amount of new taxes, the creation of new mandates, and the establishment of new entitlement programs.

Like the chamber and the National Association of Manufacturers, small businesses want and need reform, probably more so than even chamber members and the National Association of Manufacturers. But it doesn't sound as though the pending bill actually addresses the problems of small business. In fact, it sounds as though the pending bill simply creates a host of new problems—problems at a time when this country is coming back from the brink of the greatest economic downturn since the Depression.

The National Federation of Independent Businesses goes on to say:

> There is no doubt all of these burdens will be paid for on the backs of small businesses.

Over the coming weeks, I am sure some Senators are going to come down here and talk about all of the benefits for small businesses that are in this bill. But in the interest of honest debate, I hope they will at least mention in their remarks that despite all of the so-called benefits, this bill is still opposed by the voices of America's small businesses. It is still opposed by the National Federation of Independent Businesses. I could go on and list about half a dozen other business groups that oppose this bill. The Associated Builders and Contractors, the Independent Electrical Contractors, the International Franchise Association, the National Association of Wholesalers, the Small Business and Entrepreneurship Council, and the International Food Service Distribution Association—all of these groups recognize the devastating impact this bill will have on our economy.

We are facing the highest unemployment rate in 26 years. We have already seen the national debt increase by $1.3 trillion since inauguration or per household $11,535. The pending bill misses the mark on business' top priority, and that is lowering costs. Don't take my word for it. The Congressional Budget Office says the Reid bill bends the Federal spending curve further upward by a net of $160 billion between 2010 and 2019.

For these reasons, the pending bill is opposed by these organizations I have quoted: the National Association of Manufacturers, the Chamber of Commerce, the National Federation of Independent Businesses, as well as almost every other business group based in Washington, DC, or maybe, for all I know, they are based in other parts of the country, but they still follow legislation here in this city, in the Congress.

The business community has spoken, and their message is loud and clear. For Senators who want to bend the growth curve down—and that is what we all set out to do, but we don't have a bill before us that does it—this bill is not the answer. For those Senators who want to get people back to work, this bill is not the answer.

For those Senators who want to get this country's economy back on track, this bill is not the answer.

If you support American businesses—and American businesses are what provide the income into the Federal Treasury, whether it is corporate tax or income tax—it seems to me that if you have pride in American businesses and the jobs they create, you cannot support this bill.

I yield the floor.

The PRESIDING OFFICER (Mrs. MCCASKILL). The Senator from Washington is recognized.

Mrs. MURRAY. Madam President, I rise this afternoon to speak about the Transportation-Housing title of the bill now before the Senate. This is a bill that has broad bipartisan support because it addresses the very real housing and transportation needs of American families across the Nation.

There is a lot to be proud of in this conference report, and I am pleased with what we have been able to accomplish working with my colleague from across the aisle, Senator BOND, Chairman OLVER on the House side, and Congressman LATHAM and all their staffs.

This bill makes needed investments in our transportation infrastructure, creating critical jobs, while also supporting housing and services for our Nation's most vulnerable.

It ensures that two critical Federal agencies—departments that communities across the country depend on—have the resources they need to keep our commuters safe and our communities moving and prospering.

The bill before us touches the lives of Americans in ways they can appreciate each day. Because we are talking about transportation projects and housing assistance, we are also talking about jobs and stemming a housing crisis that has contributed to our current economic troubles.

Whether it is the parent who commutes every day and needs safe roads or new public transportation options so they can spend more time with their families or a business that depends on solid infrastructure to move goods and attract customers or the young family searching for a safe and affordable community in which to raise their children or the recently laid-off worker who needs help to keep his or her family in their home, this omnibus bill before us has a real impact on Americans who are struggling in these troubling economic times.

Our bill takes a balanced approach that addresses the most critical needs we face in both transportation and housing, while remaining financially responsible and staying within the constraints of the budget resolution.

I am especially pleased that the bill provides over $10.3 billion to support and expand public transit, which continues to see record growth in ridership.

The bill also includes $600 million for the competitive multimodal surface transportation grant program, which supports projects making a significant impact on communities and regions—in addition to the over $41.8 billion included for our Nation's roads and bridges, which will support good-paying construction jobs and lead to safer and more reliable infrastructure.

These transportation investments are critical to supporting our Nation's economy and creating good-paying jobs.

In addition to these important investments in transportation, the bill represents a firm commitment to provide critical housing and supportive services to families most impacted by the economic crisis.

This bill includes increased funding for the section 8 program, which provides housing for low-income families across the country. In addition, the bill increases housing programs for some of our Nation's most underserved populations, such as the elderly, the disabled, and Native American communities.

Senator BOND and I are particularly proud that this bill includes $75 million for vouchers for the joint HUD-Veterans Affairs Supportive Housing Program. That program will provide an additional 10,000 homeless veterans and their families housing and supportive services. We should all be very proud of the inclusion of that in the bill.

I am also pleased the bill includes more than $150 million for housing counseling programs to help families avoid scams and stay in their homes, instead of facing foreclosure.

Our bill provides assistance to those who need it most, and it directs resources in a responsible and fiscally prudent way.

It addresses the needs of families and businesses in every region of the country—families who are looking for the Federal Government to step up and provide solutions to everything from congestion solutions to transportation safety, to foreclosure assistance, to affordable housing.

This bill helps our commuters, homeowners, and the most vulnerable in society. Most important, it will create jobs and support the continued recovery of our national economy.

I hope we can get past the differences we have and move quickly to send this bill to the President's desk.

Before I close, I thank all our Senate staff who worked extremely hard over this past year to move this bill forward to our subcommittee, through full committee, to the floor of the Senate, through conference committee, and now here at its final stop before it reaches the President's desk. They have worked many weekends and evenings putting this together. These staff members are: Matt McCardle, John Kamarck, Ellen Beares, Joanne Waszczak, Travis Lumpkin, Grant Lahmann, Michael Bain, Dedra Goodman and Alex Keenan and especially Meaghan McCarathy and Rachel Milberg for their outstanding efforts to help us get this bill to the floor today. We are the ones who stand before everybody and take credit for these bills, but it is our staffs who have helped us get here. I thank the staffs on both sides of the aisle for getting us here today.

I urge our colleagues to get past our differences and move the bill quickly to the President's desk.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho is recognized.

Mr. CRAPO. Madam President, I wish to speak on the Omnibus appropriations bills, to which we just moved, as well as to return and make some comments on the health care legislation from which we just retreated.

First, regarding the Omnibus appropriations bill, I am very concerned about the fact that, as my motion is pending on the health care bill, dealing with one of the more important issues; namely—the President's pledge to make sure no one in America who makes less than $250,000 as a couple or $200,000 as an individual will be required to pay for the unbelievably high cost of this bill.

While we were facing that amendment, the majority has decided they will shift from the bill—I understand that is a tough vote to take because the bill contains so many hundreds of billions of dollars of new tax increases that the American people squarely in the middle class will be called upon to share. We should not have shifted from the health care debate to move to the Omnibus appropriations bill, not only because of the importance of the issues we are dealing with on the health care legislation but because of the Omnibus appropriations bill itself.

This Congress cannot control its appetite for spending. The appropriations bill we see before us now is called omnibus because it packages together seven of the original appropriations bills this Congress has been working on—and we are studying them to find out the details. But from the information I have received, the average rate of growth in spending in this bill overall—over those seven bills—is somewhere between 12 percent and 14 percent growth in

Federal spending.

This Congress has generated a $1.4 trillion deficit in less than 12 months. For next year, we want to see Federal Government grow by another 12 to 14 percent. That doesn't count the new stimulus package spending that is being talked about, and it doesn't count the spending—that almost $2.5 trillion in new spending—contemplated in the health care legislation, and any number of other pieces of legislation waiting in the queue to come before the Congress.

At some point, fiscal restraint has to return to Washington, DC. We have not seen it here for far too long. I know it is very tempting to just say we can pile the debt on our children and grandchildren and spend what we want to spend today. There are those who say the only way we can have a strong economy is to spend ourselves into prosperity. Yet it is not the government that creates jobs. It is the formation of capital, the investment by small businesses and entrepreneurs in new ideas and products, and the expansion of business in the United States that will allow us to sustain a strong, healthy growth in our economy.

If we continue to rely on borrowing money from the future in order to

spend ourselves into prosperity, we will continue to see our national debt mount to a point where it cannot be sustained. We are already at a $12 trillion national debt, a national debt that is projected to double over the next 10 years to $24 trillion. I object to moving off the health care bill, where we had such critical amendments and motions pending. I object to moving to a bill that will now increase the spending of the Federal Government by 12 to 14 percent.

Let me shift for a moment and talk more about the health care bill. The motion I had brought—the pending motion before the Senate—or it was before we shifted off the health care bill—was a simple motion that would have required the bill to be committed to the Finance Committee, with instructions to the Finance Committee to take out those parts of the bill that impose a tax increase on people in the United States who earn less than $250,000 as a couple or $200,000 as individuals.

Very straightforward, it is exactly what the President pledged he would do, on multiple occasions, to the American people. Yet we have shown there are almost $500 billion of taxes in the first 10 years of this bill. If you look at the real first 10 years after the spending has kicked in—the 2014 to 2023 time period—it is almost $1.2 trillion in new taxes, a huge portion of which falls on the middle class. The response has been that actually this bill is a net tax cut. How can that be? The only way it can be claimed to be a tax cut is if you take the subsidies in the bill—about $400 billion worth of them—which are used to provide people at lower income categories, who don't have adequate access to insurance, with a subsidy toward the purchase of insurance and if you call that a tax cut. In the bill, it is actually called a renewable tax credit—even though $300 billion of the $400 billion goes to individuals who do not pay taxes, do not have a tax liability, and it is scored by the CBO as spending, not tax relief. Even if you were willing to count that money as tax relief, then you would have a situation in which 7 percent of the Americans would be receiving these government subsidies, while the remainder would be paying the price—paying the taxes.

To put some numbers on that, out of 282 million Americans who have insurance in America today—or will have in 2019—only 19 million would receive this tax credit being talked about. Remember, the vast majority of them get what is called a tax credit, but it is a government subsidy going to those who have not generated a tax liability, and 157 million of the 282 million would be people who get health insurance through their employer and will not be eligible for that health insurance.

After you do all the numbers and take out the taxpayers who make less than $250,000 a year as a couple or $200,000 as an individual, the bottom line is, after all those who are subsidized are taken out, there are still 42 million Americans in the middle class, as defined by the President, who will pay hundreds of billions of dollars in taxes.

My amendment would simply require that those taxes be taken out of the bill, the President's pledge be honored in the bill, and the bill then be put into a posture to return to the floor for further debate.

There is one other item I would like to talk about. One of the things that is often said by the opponents of my amendment is that this bill actually drives down the spending curve.

When they say that, I wonder what curve they are talking about. Are they talking about the size of government? No. The size of government under this bill grows up by $2.5 trillion. Are they talking about the cost of health care? No. The CBO study indicated very clearly that at best Americans will not see the cost of their health care go down. For those in the most needy categories, the 17 percent of Americans who are in the individual market, their health insurance will actually go up by 10 to 13 percent.

Are they talking about the Federal deficit? Actually, CBO says the deficit will go down. That is not the size of the government, but that is the size of the debt or spending each year. But how does it go down? It goes down only if you use the budget gimmicks that I will outline in just a minute or if you include all the taxes, the hundreds of billions of dollars of taxes that are in the bill, and if you count the Medicare cuts that are in the bill.

Take out any one of those—the nearly $500 billion of Medicare cuts, the nearly $500 billion of taxes, or the budget gimmicks—and this bill does not drive the deficit curve down.

What are the budget gimmicks—and I will close with this—what are the budget gimmicks about which I am talking? There are a number of them. The biggest is that the proponents of the bill do not count the first 4 years of spending. If you look at the 10-year spending cycle of the first 10 years of the first part of this bill, the taxes go into effect on the first day the bill is law, on January 1 of next year. The spending does not start until the year 2014.

So we have 10 years of taxes, 10 years of Medicare cuts, and 6 years of spending. That is how they are able to say it balances out. If they started the spending and the taxing on the same day and did not give themselves a 4-year run of tax collection until they start the actual implementation of the spending part of the bill, it would drive the deficit down also.

All we need to do in this Senate is to slow down, refer the bill back to committee, have them fix the provisions on taxes, and then work on some of the common ground we know we have that will help bend the spending curve down and will help improve the situation for Americans across this country who are calling for us to control the skyrocketing costs of health care.

It is my hope that as the Senate goes through the next few weeks of debate on this legislation, as well as the other legislation we bring before us, we will remember our children and our grandchildren and all Americans today who are calling for the kind of true health care reform that will truly address the kind of fiscal responsibility and the kind of cost containment that we should be seeking in this Chamber.

I yield back my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Madam President, I rise to reiterate exactly what my colleague just said, that transparency with the American people on the cost of this plan is absolutely essential. If you are going to tax the American people, tell them what you are going to tax. If you are going to cut their benefits, tell them what you are going to cut. Do not use smoke and mirrors to create a panacea for the people down the road to find out they have been sold a pig in a poke.

I want to talk about not what has been introduced but what has been reported in the press as to where we may go on this bill.

As many know, the bill that is under consideration that is supposed to reform health care is a bill that was crafted in a back office in the Capitol where very few people participated, and those who did participate were only Democrats. It was not until it was rolled out on the Senate floor that many of us had an opportunity to read the 2,074 pages. If the American people are like I am, we are still working our way through section by section trying to figure out exactly what it says and, more importantly, exactly what it means and, even more important than that, how does it affect me? How does it affect my family?

You see, health care is a very personal issue for everybody in this country. It is important that we display the honesty they expect from us. If, in fact, we are going to reform health care, then let's reform it. If we are going to do what we have done over the past several weeks, which is have a debate about coverage expansion, then let's be honest with the American people. Who is going to pay for it?

We know how CBO looked at the bill and how it was designed by the majority leader. They are going to steal $464 billion from Medicare. That is a fact. Nobody disagrees with that. Madam President, $464 billion would be stolen from Medicare which the Medicare trustees say will be insolvent in 2017, a mere 8 years from now. I am not sure that is fiscal responsibility, but it is in the bill.

In the last 24 hours, the press reports the majority leader has sent a new proposal to CBO, the Congressional Budget Office, because he is seeking to find out what that new proposal will cost. If the reports are correct, he has decided to drop the public option and to craft a new coverage plan for some segment of

the American people. Again, by news accounts only, that would be an expansion of coverage for individuals in this country 55 to 64. I do not know whether that is the entirety of the group. That is 24 million to 30 million people. The likelihood is if it were opened to any segment, it would be like a magnet to those who probably had some type of health condition because if you do not have a health condition, the likelihood is, in the open marketplace through your employer, if you are employed, you can find a reasonably priced plan. Automatically, the way we have designed it is we are going to attract the sickest of that population.

In the process of doing that, we have to pause for a moment and realize that we have over 40 million seniors and disabled already in Medicare. It is a system that does not reimburse for 100 percent of the services provided. In other words, for Medicare, we reimburse a doctor and a hospital less than it costs them to deliver the service. Nationally, we have accepted that because in that system, when a senior goes in under Medicare and gets a service, what is not reimbursed is then shifted over to the private sector side. It is shifted over to people who pay out of pocket. It is shifted over to people who have private insurance.

Doctors and hospitals have been successful at managing their payer mix. A lot of doctors have X amount of Medicare, X amount of Medicaid, and X amount of private pay. When they put them all together, they find a way to stay in business.

I think it is safe to say if you change the doctors' payer mix or you change the hospitals' payer mix, you could take a provider and move them from slightly profitable, enabling them to practice, over to losing money based upon how the payer mix reimburses them.

My point is, as you take people out of private pay, which is coverage by their employer under a health care plan, payment out of pocket or purchase of health insurance, where that health insurance pays at 100-plus percent of the cost of a service provided, we are basically putting 24 million possibly new additional covered lives into Medicare under Medicare reimbursements. Through that, we automatically change the payer mix of every potential provider in America. We put in jeopardy the doctor. We put in jeopardy the hospital. We put in jeopardy anybody who provides a service under Medicare.

What is the doctor going to do? The doctor can look at it and say: I can absorb the reduction and the change in the payer mix or the doctor may look at it and say: I cannot add any more Medicare beneficiaries. I am sorry, I saw you before when you were on private insurance, but I cannot continue to see you because now I do not get reimbursed sufficiently. So you are going to have to find another doctor.

Now we have gotten into the core pledges of the President where he said: If you like your plan, you get to keep it; if you like your doctor, you can continue with him. We are putting a burden on the doctor or the hospital to make a determination as to how they monitor and control their payer mix by one simple change: by increasing the opportunity for people to participate in a program that up to this time has been sacred and, I might also add, is a program that every participant has paid in their lifetime to be enrolled in.

Medicare is a trust fund. I think we forgot that, when we arbitrarily said we can take $464 billion and steal it out of Medicare and use it to fund this new entitlement. This is not our money to steal. This is the beneficiaries' money that they have paid taxes on their entire life to fund their Medicare benefits.

I am not sure why we believe we have the right to go in and move that money from one account to another, where, in essence, we are moving it from one account and using it for somebody totally different. It is unfair to those who planned a lifetime for this.

Let me go back to the payer mix. As you increase the rolls of Medicare beneficiaries, you affect the viability of every outlet of medical services—hospitals, doctors, this could also affect pharmacists. It is important that we realize we have already increased in this bill the number of individuals who will be covered under Medicaid. The majority leader's original bill mandates that every State will now raise their limit on Medicaid participation from 100 percent of poverty to 133 percent of poverty. Medicaid reimburses at about 72 cents of every dollar of service provided. When you do that, you have now enrolled between 11 million and 15 million new covered lives under Medicaid.

So every provider in the system is already looking at what has been proposed—until the press accounts of the last 24 hours—and said: I am going to have 11 million to 15 million more people. I am being reimbursed 72 cents of every dollar provided. It is hard to stay in business when it costs you a dollar to deliver a service and you get 72 cents back as payment.

They are already trying to figure out how they are going to adjust their payer mix to meet the demands when all of a sudden we come out with a new proposal that the press accounts say we could enroll 24 million people in, that further contributes to cost shift.

Let me say to my colleagues, I was in full agreement with the President when he came out and said: Here are our goals. We have to reform health care. We have to focus on making sure every American has access and affordable options to health care. We have to make sure it is fiscally sustainable.

Why, in the 21st century, would we design a health care system that we could not be certain was financially sound for generations to come?

The truth is, by every account, in a real 10-year period, 10 years of taxes and 10 years of benefits going out, this bill before the revision yesterday is a $2.5 trillion bill. It will contribute to the debt. It will borrow money that our children will be obligated to pay interest on and pay back.

This just compounds the problem, a breakthrough. This is not about policy; this is about in a back room in Washington in the U.S. Capitol, where the majority leader was trying to get to 60 votes. It is real simple.

Listen to the American people and we would start over and we would start over with the principles of the President: Make sure what you do reforms health care, attracts 100 percent of the American people because of access and affordability, and it is fiscally sustainable for generations to come.

The truth is, we have been on the Senate floor for 2 weeks. We have debated a bill that does coverage expansion. I admit openly, it covers 31 million more Americans. But it misses the mark of doing any health care reform because, you see, the bill, before the press accounts of the last 24 hours, assured every American that if they had private insurance or they paid out of pocket, their health care costs were going up. There is no way they could not.

Now what we have done is we have shifted and said we are going to increase the amount of the cost shift. Let me explain for just a minute what a cost shift is. Cost shift is when somebody goes in and is provided a medical service, and if they do not pay for that service or they do not pay the entire cost of that service, what is left over is shifted somewhere in the system. Well, somewhere in the system is the next person who walks in with insurance or who pays out of pocket. Because of the blend they have to meet, they pick up the difference.

Why has health care had such a phenomenal increase in cost? It is because as we increased the rolls of Medicaid, as we had more seniors go into Medicare, we had more costs that were shifted. Up to this point, the President, the Congress, and others were only focused on the uninsured and the underinsured. Well, they are a contributor to the cost shift, there is no question. But let me suggest to you that if we provide insurance—and we should provide access and affordability for every American. By putting people into Medicaid, all you are doing is exacerbating the cost shift. If, in fact, you create a health care system that has an incentive for an individual not to purchase their own health care because it is cheaper to pay the fine, all you are doing is exacerbating the problem of cost shift.

Health care reform is about changing the health system so that cost shift is eliminated. Quite frankly, it starts with making sure we pay 100 percent of what the cost of the services are. But we are not having that debate. This debate on the Senate floor right now, 2 weeks before Christmas, is about coverage expansion. It is not about health

care reform. If it were about health care reform, we would be talking about how we create an incentive for private companies to create products that allow an individual to construct their health insurance so that it matches their age, their income, and their health condition. That is not what we are doing. We are sitting in Washington, creating a one-size-fits-all program and saying: You know what, if this doesn't fit, well, we are going to create a government option for you, and we will subsidize you and put you in the government option. Where is that fair to the American taxpayer?

That is why Senator CRAPO's motion is so important. Refer it back to committee. Start over. We have our priorities wrong as it relates to our ability to dip into the American people's pockets and use their money to fund something that is not going to benefit them one bit. This would be a different debate if we could look at the people who are not covered and say: We have fiscally maximized our ability to provide you health care but not necessarily abused the American people's pockets to do it.

America is the most compassionate country in the world. But when we debate things such as this, we are also the most foolish country in the world because it is irresponsible on our part to abuse the power of this government to spend money like this without the benefits that we set out to achieve.

So it is my hope that as we go through the weekend, we will have an opportunity to see what the new proposal is that is laid down on the table. Again, I have to go by what I read, and that is not always accurate in this town.

The CBO has stated that a similar proposal, which was a proposal for a buy-in at the age of 62, would result in an adverse selection in the Medicare Program and would drive up premiums. Let me quote CBO because I don't want it just to be me. This is what the CBO said:

> A potential problem with this option is that the amount of adverse selection that the program experienced could be greater than anticipated, which would put upward pressure on premiums.

CBO is the entity that is evaluating the cost of the current proposal, which nobody knows what is in it. But this was a proposal that was sent to them some time ago that had the buy-in starting at 62, not 55, and their assessment of it, with a buy-in of 62, is that the adverse selection—meaning more sick people were going to migrate to this new option—would cause upward pressure on Medicare premiums and upward pressure on premiums across the board.

So it is my hope that we will have an opportunity very soon to know what is in the proposal and to be able to debate the facts versus just trying to educate ourselves based on the leaks from the media. But there is one thing for certain: The American people have voiced their position on health care reform. They do not see it as reform. They do not see it as positively affecting themselves. They see it as too expensive, they see it as a breach of trust on a plan that seniors have become 100 percent reliant on because they paid into it.

This path has a lot of problems. It is not just the new proposals, it is the proposal that has been on the table for some time. It is my hope that we will continue this debate as long as it takes to make sure that at the end of the day we do what is right for the American people and not necessarily what is expeditious for Members who would like to be home for the holidays.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, earlier today I explained to my fellow Senators, and hopefully to my friends in the media, that the Reid bill does not provide a net tax cut for Americans. Contrary to the Democrats' claims, that seems to be the situation. They claim there is a net tax cut. I hope I proved earlier today that it does not have a net tax cut. Some Americans are cut, but don't forget that some Americans have increases in taxes. I pointed directly to this data, as prepared by the Joint Committee on Taxation, to show that a group of middle-income taxpayers will see their taxes go up under the Reid bill, and that would be this class of taxpayers right here. I don't disagree with Democrats saying there is $40,786 million of tax cuts, but there are also tax increases for a large share of Americans.

I want to now build on those earlier remarks. As I stated, there is clearly a group of individuals and families who benefit from the government subsidy for health care. However, that group is relatively small. Another much larger group would see their taxes go up. So I want to take a minute to provide some statistics that we pulled from the data of the Joint Committee on Taxation looking at both the winners and the losers under the bill.

For the benefit of the public, the Joint Committee on Taxation is an intellectually honest group of professionals who are nonpartisan, and they give Congress information on the impact of policies we make here in our various committees or as individuals or the Senate as a whole.

According to this professional group, the Joint Committee on Taxation, out of those individuals and families affected by four major tax provisions under the Reid bill, individuals earning more than $50,000 and families earning more than $75,000 would see, on average, their taxes going up. Only individuals with incomes below $50,000 and families with incomes below $75,000 would, on average, see some tax relief on account of receiving subsidies for health insurance.

The data of the Joint Committee on Taxation indicates that in 2019, individuals earning less than $50,000 would, on average, receive tax relief through this subsidy equal to $875. Families earning less than $75,000 would, on average, receive tax relief equal to $2,031 from the subsidy. This so-called tax relief, however, is in the form of an advance refundable tax credit that is delivered directly to the insurance company providing health insurance coverage, not to the individual but signed, sealed, and delivered directly to the insurance company—100 percent of it. I repeat: not to the individual but to the insurance company. Clearly, this group is a winner under the Reid bill. But the same data from the Joint Committee on Taxation indicates that in 2019, individuals earning between $50,000 and $200,000 would, on average, see a tax increase of $593. That is for individuals. Now, let's go to families earning between $75,000 and $200,000. They would, on average, see a tax increase of $670.

So what does all this mean? This means the Reid bill does not cut taxes for all Americans. To the contrary, the Reid bill breaks Obama's promise not to tax individuals making less than $200,000 and families making less than $250,000 a year. And you just can't know how many times President Obama, during his Presidential campaign—whether in debates or in individual appearances when he was a candidate—made it very clear that nobody with under $200,000 a year in income was going to see a tax increase. To the contrary, the Reid bill breaks President Obama's pledge not to tax individuals making less than $200,000, and then a higher figure for families making less than $250,000.

Does the tax relief provided to individuals earning less than $50,000 and families making less than $75,000 represent a tax cut? Generally, no, because based upon the report of the Joint Committee on Taxation, of the $395 billion the government will spend on tax credits for health insurance—or subsidies for health insurance—$288 billion will be refundable, meaning individuals and families who have no tax liability will still receive the full benefit. The Joint Committee on Taxation tells us that the remaining $106 billion will go toward reducing real tax liability.

The Congressional Budget Office classifies a benefit provided to tax filers with no tax liability as government spending, not as a tax decrease. This is compared to a tax benefit that actually will reduce a taxpayer's tax liability. This means the $288 billion of government spending through the Tax Code cannot be considered a true tax reduction.

The Democrats count the $288 billion in government spending when claiming the Reid bill provides a tax cut. And the reason is if the Democrats do not count this government spending as a tax cut, they could not hide the fact that the Reid bill increases taxes.

Bottom line: The Reid bill does not provide a net tax cut. Instead, the bill

raises taxes and it raises taxes on individuals and families earning less than $250,000, contrary to Candidate Obama's presentation during the campaign that nobody below that figure would get a tax increase.

Check the data. No one can dispute it. It is right here in these figures. Everybody in the United States is represented by these figures here highlighted. They are the ones who are going to get a tax increase. That is the rest of the story.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Madam President, we are on the floor today, as we have been for many days and weeks now, discussing health care. One thing I think is undeniably clear is that there is a basic divide in the Senate on health care. That is not news to most people. But I believe on this side of the aisle there is a great deal of consensus about what health care reform should be about.

We have been trying throughout this debate to make it very clear that we are not only concerned about the tens of millions of Americans who do not have any insurance at all—that is obviously a focus of our work and focus of the debate—but we are also concerned at the same time, as we must be, with those who have insurance—with families with insurance, families who believe they have the security of insurance but, unfortunately, under our system many of them don't.

Many families, in fact millions of families, over the last couple of years have had a member of their family denied coverage because of a preexisting condition. That should be illegal. In this legislation we deal with that directly for the first time ever.

We also provide other protections. When you say ''consumer protections,'' that is a nice sounding phrase but in some ways it does not describe what we are trying to do. We are trying to prevent people from being denied coverage because of preexisting conditions. We are trying to make sure that other families don't have a tragedy such as the family I have spoken on before on this floor, the Ritter family in Manheim, PA. They had the tragedy of finding out a number of years ago that their two 4-year-old daughters, twins, had leukemia but also the insult and the outrage of our system saying to them: Your daughters have leukemia, we can treat them, we have a lot of experts and knowledge and technology to help them, but we are going to limit their care.

That is an outrage. The first provision in this bill says we are not going to put caps on treatment for people who are very sick.

We also recognize that, as President Obama said a number of months ago, if you get sick, you shouldn't go bankrupt. But that is happening more and more in America. It is an outrage and we should not allow it to go on any longer.

We are trying also to keep premiums affordable. Fortunately, the Congressional Budget Office helped us make that argument. In their own way they weighed in on that question and talked about the fact that so many American families will have their premiums reduced if not kept level.

We are obviously trying to enhance quality and prevention. All of these strategies that we know work, the research is irrefutable, but we talk about them as a way of a good example instead of talking about them as something we ought to put in the law and make part of our system. Why should we have all of those prevention strategies and then throw up our hands and say that would be nice if insurance companies did that in their policies instead of make it part of the law. And we will, both in terms of prevention strategies as well as quality.

Finally, as a quick summary of what we are trying to do, we are trying to control costs. I think this bill does that. We still have a bill to do and amendments to make. It also cuts the deficit by $130 billion over 10 years, and much more, several hundred billion, in the years after that.

One fundamental recognition, I guess, in this debate—at least on this side of the aisle—is that our system has left people out. In some cases it has left them out in a very tragic way when they are denied coverage because of a preexisting condition. Our health care system has left out others in different ways, and I rise today to speak about an amendment I filed, along with Senator KLOBUCHAR, my cosponsor on this amendment, that seeks to address a group of Americans who have been left out of our health care system and forgotten at a very difficult time in their lives. The name of the amendment is the Pregnant and Parenting Teens and Women Amendment. It recognizes what I believe to be a fundamental reality in America. I will describe two scenarios—one that so many of us have had the opportunity to experience as parents but especially those in this Chamber and those who are listening to this debate who are women who become pregnant.

For many women that moment when they find out they are pregnant is a moment of joy. It is the miracle of pregnancy. They feel that joy and they share it with their family and their friends. It is a time of real happiness. Many of these women in that first scenario do not need help beyond what their families provide or what they might receive by way of adequate support within our existing framework of programs and services—whether that is government help or private sector or nonprofit help. That is wonderful and we hope that becomes more and more the case.

But there is a second scenario in America, a second category where a woman finds out she is pregnant and that moment of discovery is not a moment of joy. For her, it is a moment of terror or panic or even shame. She may be in a doctor's office or she may be at home—she may be in a number of places—but for her that moment begins with a crisis in which she feels overwhelmingly and perhaps unbearably alone, all alone. She could be wealthy, middle income, or poor—but most likely, if that pregnancy is a crisis, she is poor. Whatever her income, she feels very simply all alone.

A pregnant woman who is facing those horrific circumstances may be a woman who has an abusive spouse or boyfriend who is tormenting her. She is all alone in many instances.

Another pregnant woman may believe that she cannot support or care for her new baby at this point in her life. She is all alone.

Another woman might believe that her financial situation is so precarious that she cannot care for or raise a child. She may feel all alone and helpless. If she decides to bear a child, she needs our help. She needs our help to walk with her along that difficult journey—not only through the 9 months of her pregnancy but also through the early months and years of that child's life.

I believe that is an obligation we have. I know some may not agree with that, but it is important that we are honest about where we stand.

We understand that many women face that reality. So what do we do about it? Do we say: That is too bad and that is kind of their problem and let them find their own way or there is a little program down the street that might help them or there might be a little government program over here or there might be some charity that will help them. They will do fine. Don't worry about them.

This country has shown a capacity to reach out and help people who are in crisis, to try to give people a sense that they are not all alone, that there are lots of ways to help. Unfortunately, neither political party has adequately met this challenge, in my judgment. We hear a lot of discussion about it. We hear a lot of sentiment about it. But we do not do nearly enough about it.

Here is what the amendment will do. First, it will provide assistance and support for pregnant and parenting college students. Second, it will provide assistance and support for pregnant and parenting teens. Third, it will improve services for pregnant women who are victims of domestic violence, sexual violence, and stalking. And fourth, it will increase public awareness of the resources available to pregnant or parenting teens and women.

Let me give some examples of these services. First, funding for colleges to provide pregnant and parenting resources located on campus or within the local community and improve such resources, including: the inclusion of maternity coverage, which a lot of insurance companies do not provide now, unfortunately and insultingly, in my judgment; make available riders for

coverage for additional family members in student health care on a college campus; make sure that woman, if she has chosen to bear a child, gets housing and childcare and flexible or alternative academic scheduling to allow her to remain in school; education to improve her parenting skills; maternity and baby clothing, baby food, baby furniture—all of the things some of us take for granted in our families prior to or upon the birth of a child.

The other part of this is funding for programs that help pregnant and parenting teens stay in or complete high school and prepare for college or vocational education, by providing resources and assistance.

Next, assistance to States in providing intervention services, accompaniment and supportive social services for pregnant victims of domestic violence and other kinds of violence as well, to start.

Finally, making people aware, providing public awareness and outreach so that pregnant and parenting teens and women are aware of the services available to them.

We cannot stand here on the floor and say we care about these folks and we want to help them if we are not willing to make good on that promise. It is not enough to have good intentions. It is not enough to say there might be a program out there. We know for sure that at least these three categories—maybe others could add to it, maybe others may not, but these three categories of pregnant women are in many cases all alone. Neither political party nor our Government—and I would argue other parts of our society—are doing enough. It is time as we debate health care that we say one part of our health care system is going to be made much better.

In addition to the substantial changes on protecting families from the ravages of what insurance companies have done to some families, protecting them at long last, those with insurance, ensuring 30 million Americans, cutting the deficit, having prevention strategies, controlling chronic disease and making it something we can manage better, and save money—all of that is important. But I do not think in the debate here we should leave out those who are asking for a little bit of the help we are not giving them.

We should never ask a pregnant woman to walk that journey all alone. I think that is the least we can do in this Chamber, in this debate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Madam President, my friends on the other side of the aisle have taken to the floor to make the argument in favor of the Reid bill that it eliminates a so-called hidden tax. What is this so-called hidden tax? The other party argues that there is a hidden health tax that families pay in increased premium costs to cover the costs of caring for the uninsured. In short, when doctors and hospitals provide treatment to the uninsured they are forced to compensate for this ''uncompensated care'' and do so by charging more to private health insurers. The cost of this care that is shifted to the insurers is then passed on to health care consumers in the form of higher health insurance premiums. Unfortunately, this so-called hidden tax is often overstated.

Families USA conducted a study attempting to quantify the cost shift associated with uncompensated care. According to this study, about $43 billion in uncompensated care is shifted to private health insurance which led Families USA to conclude that there is a hidden tax of about $1,100 that families pay in increased premiums. A Kaiser Family Foundation study dissected the Families USA numbers and estimated that the total amount of uncompensated care shifted to private insurers was closer to $11 billion, making the so-called hidden tax around $200 for a family, compared to the $1,100 that Families USA said. Let me give some ground to my friends on the other side and assume that the hidden tax does equal that higher figure, $1,100, as compared to the Kaiser Family Foundation figure of $200.

The Democrats' bill does not get rid of the hidden tax entirely. Actually, this bill makes it worse. How? First, the Democrats' health care reform bill still leaves a large number of Americans uninsured. Specifically, the Reid bill leaves 23 million out of 54 million still without health insurance at the end of this decade, remembering that this bill does not actually take effect until 2014. So between 2014 and at the end of the budget window, we still have 23 million people without health insurance. At best, the reform in this 2,074-page Democratic bill cut the hidden tax in half; in this case, to about $500 for a family.

The Reid bill adds, however, new hidden taxes. These impose $67 billion worth of so-called fees on health insurance companies and self-insured arrangements beginning in 2010. The Congressional Budget Office, the Joint Committee on Taxation, the nonpartisan experts and official congressional scorekeepers have testified that these fees will be passed on to health care consumers.

The Congressional Budget Office and the Joint Committee on Taxation have further testified that this will result in higher insurance premiums for all Americans. The actuaries at Oliver-Wyman estimate that the fees imposed on health insurers would add $488 to the cost of the average family health insurance policy. A new hidden tax is also created as a result of the Medicaid expansion and Medicare cuts. The major cost shift in health care derives from the government programs, Medicare and Medicaid, which reimburse providers at rates roughly 20 percent to 40 percent lower than what private providers pay to the same doctors and hospitals.

President Obama understands that paying doctors below market rates leads to a cost shift. After all, in a townhall on health care reform, the President said:

> If they're only collecting 80 cents on the dollar, they've got to make it up somewhere, and they end up getting it from people who have private insurance.

The Medicare and Medicaid cost shift will be increased significantly under the Democrats' health care reform bill. According to CBO's estimate, Medicaid will be increased by more than 40 percent, from 35 million to 50 million people by the end of the budget window in 2019. Additionally, the bill includes almost $½ trillion in Medicare cuts which will result in lower payments to providers.

The actuaries at Milliman Consulting studied the current cost shifting resulting from Medicare and Medicaid underpaying providers and found that this cost shift for Medicare and Medicaid totaled almost $89 billion per year, adding $1,788 to the current family health insurance policy. Increasing the current Medicare and Medicaid cost shift, as a result of this 2,074-page health reform bill before us, would add even more cost to a family health insurance policy.

The easier cost shift to address would be the $1,700 cost shift from defensive medicine. The Democrats do not address cost shift from defensive medicine which Dr. Mark McClellan, former head of CMS, and Daniel Kessler estimated adds $1,700 in additional cost per average family. Addressing this reform alone could save more than covering all of the uninsured.

So you see, the Democrats say their bill will eliminate the so-called hidden tax. My friends seem to come up short on that one. Also, my friends add new hidden taxes that will burden middle-class Americans.

I ask my friends to be transparent when they are talking about getting rid of the hidden tax. The Democratic health reform bill actually makes things worse.

I yield the floor.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Utah.

Mr. BENNETT. Last night, I held a telephone townhall meeting. As usual, because we get over 10,000 people on the telephone townhall talking to us, I said: This is a meeting that is open to any subject you can talk about.

Overwhelmingly, they all wanted to talk about health care. I had one call where the fellow said he liked this health care bill. He was a small businessman. He said: This will help me as a small businessman, and why are you opposed to it?

I said to him: I have been a small businessman, and I would like to point out to you that NFIB, the organization that helps small business, is opposed to it. And I went through some of the reasons. Then I told him of other small- or

medium-size businessmen in Utah who have said to me: If this bill passes, we are out of here. We could do our manufacturing overseas. We could send our product to South America and have it made there. We have stayed in Utah more out of patriotism than money. But if this bill passes, the impact on us in small business will be sufficiently great that we will leave Utah. We will leave America. We will take all of these jobs and go overseas.

That was that one discussion with the one caller. Every other caller talked about the health care bill and said: Don't pass it. Every other caller was opposed. There was only the one who made comments in favor of it, comments on which I think I was able to dissuade him.

Every other one came up: Do you want to talk about Afghanistan?

No, we want to talk about health care. We are opposed to this bill.

Do you want to talk about some other aspects of what is going on in Washington?

No, we want to talk about health care, and we are opposed to this bill.

Over and over, the only other subject that came up that I can recall with any regularity—there were several calls that talked about cap and trade and expressed their opposition to that. But, overwhelmingly, the entire hour was people who were saying: We are opposed to this bill.

I want to share with the Members some aspects of the reaction of Utahns to the campaigns that have been mounted by various groups in favor of this bill. Let's go to the campaign that has been mounted by the AARP. AARP is one of the strongest lobbying organizations in the country. Indeed, there are those who say it is the most powerful lobbying organization. AARP, in an effort to make sure this bill gets passed, has prepared preprinted petitions and sent them out to their members. Here is a copy of one. It is addressed directly to me and was sent to people in the State of Utah: ''Petition to Senator Robert F. Bennett. Dear Senator Robert F. Bennett, As one of your constituents . . . '' so on and so forth.

Then all the AARP member has to do is sign it and send it to me. This one was sent to me. But as we can see, he didn't just sign it, instead he wrote on it. This is what it says in handwriting:

> Absolutely not! Please vote against current legislation being proposed by the current administration and endorsed by the AARP.

The ''not'' is underlined. He signed his name. I have taken it off this facsimile to protect the man's privacy, but he made it clear that he was not in favor of what the AARP was saying and doing in this situation. We have others who have said the same kind of thing.

Here is a letter I will quote from:

> Senator Bennett, please do not vote to pass the health care bill that contains a public option. The present medical is broken and surely needs fixing. However, it should be done in ways that do not bankrupt the country, close hospitals and doctors offices.

Who is saying this? He says:

> I will probably withdraw from AARP since they support the present health care proposals. Several of my doctor friends have withdrawn from the AMA due to its support of these proposals.

Then he signed his name, and his initials make it clear he, too, is a physician, a member of AARP who clearly wants to drop out of AARP, and a member of AMA who supports those who drop out of the AMA.

Let me quote from another physician who wrote a lengthier letter, more analytical. I will quote from parts of the letter. He starts out:

> As a practicing Utah physician, I see and treat patients every day. I try to accurately diagnose what their troubles are and offer an incremental plan for their recovery. I am thorough, methodical and exacting in my plan, purposely first doing no harm, as my Hippocratic oath reads, not making the situation worse, not causing more pain or suffering. The Senate bill before you will make America more ill, with increased pain and suffering. I plead with you to first do no harm. Please do not make the situation worse as with the current bill. It is beyond repair. Please recognize that the Senate plan will add to America's ills.

Then he goes on later in the letter to make this comment:

> Patients ask me why the AMA appears to support this bill. They sense that the AMA is not looking out for patients and doctors. I agree that the AMA is misdirected and explained that the AMA represents fewer than one in five U.S. doctors and has compromised its mission.

I find that interesting. I didn't realize that the AMA membership had dropped so low. When I first became interested in politics, the AMA represented virtually every doctor in the country. Not anymore.

I tell my patients about the multitude of other medical organizations of which I am a member, state medical organizations, speciality groups, and the Coalition to Protect Patients Rights, representing thousands of doctors who actively oppose the Senate bill in its entirety and are fighting for patients and the right fixes for affordable, quality care.

Well, as I found out in my telephone town meeting, which covered the entire State—and with no filtering on the part of my staff as to who could get in and who could not—this is, indeed, very clearly the majority opinion for members of the State, seniors who presumably belong to AARP, and physicians who either used to belong to the AMA or understand the AMA.

Here is an e-mail from a doctor. I cannot pronounce the specialty he is in. He says:

> As a constituent and practicing—

And then he goes on to say whatever kind of ''ologist'' he is—

> I strongly urge you to oppose the passage of the current Senate healthcare reform legislation. . . . Although our nation would benefit from targeted healthcare reform, the proposed legislation is not the answer and will harm, not help, healthcare delivery in our nation. . . .
>
> As surgeons, we take pride in our work and strive to provide the best patient care possible. We will support reform efforts that truly preserve access to high qualify specialty care without jeopardizing the physician-patient relationship. As such, I oppose the ''Patient Protection and Affordable Healthcare Act'' as it has the potential to seriously compromise the delivery of healthcare in the United States by creating additional pressures on an already overburdened healthcare system.

Well, I have a number more. I will not go into all of them; I will just pick a few from the stack I brought with me.

Here is one:

> I am a Surgeon who has been practicing for about 30 years. I am against the total overhaul of the health care system. All entitlement programs are not cost effective and all are in danger of bankrupting the U.S.

Here is one, who is a retiree, who says:

> Please vote against these healthcare ''reforms'' that will limit options, cost us all more and reduce our freedoms. We need real change: portability, tort reform, and less government control.

Back to the doctors. He says:

> Dear Mr. Bennett,
>
> I am a pediatrician in Utah and met you at the hospital in Orem. Thank you for your opposition to the current process happening in Washington. We do not need to rush through and push the American people into government run health care and more red tape. Medicaid is already my biggest head ache in my practice.

And so on and so forth, as I say.

I want to make this other point with respect to all of these people who are so concerned that we will have an immediate bad impact if this bill passes. They do not realize—and I did my best to point this out to those who were on the telephone townhall meeting last night—that this bill will not fully take effect—indeed, most of the aspects of this bill will not take effect—until January of 2014. That is correct, January of 2014—4 years away.

Here we are meeting on weekends, coming in here on Sunday, driving to get this done by Christmas because it is so pressing that we have to do it, and, by the way, we are not going to start, really, any of these reforms for 4 years. So these people who are writing me, these doctors who are complaining about AMA's endorsement, these people who are complaining about AARP not representing them, are worried about an immediate impact.

Let me tell you what the immediate impact of this bill will be. The immediate impact of the bill will be financial. The taxes will take place immediately upon passage. The increase in premiums will begin to start on passage, as the pressure on the insurance companies, the pressure on manufacturers, the pressure on pharmaceutical companies will all begin with the passage of this bill. But all of the wonderful things we are being promised as benefits from this bill will be delayed for 4 years. Why? There is only one reason why: in order to use smoke and mirrors in the budgetary process to

make it look as if this is cheaper than it really is. If you get the money coming in for 10 years but the expenses only going out for 6 years in your calculation, it looks as if it is a whole lot cheaper than it really is.

The only honest way to score this is to say the expenses start the same day the taxes start, the expenses going out start the same day the revenue coming in starts. Then you get an accurate description of how much this costs.

I cannot imagine any businessman going before his board of directors and saying: I have a new program I want to institute in this company, and it is going to cost X, and here is how I have calculated it is going to cost X. I am calculating the revenue from the sales of the product over a 10-year period, but the actual sales will only occur in the last 6 years.

His board of directors would take one look at him and say: There is no way we can make a strategic plan based on that kind of smoke and mirrors. What in the world is wrong with you to do accounting of that kind?

He will say: That is the kind of accounting I learned from the U.S. Senate—start counting the revenues immediately, but don't count the expenses until 4 years later.

Well, let's look at the impact of that 4-year gap and tie it to the messages I am receiving from my constituents, and I think we will see something very interesting happen. Between now and the time the benefits of this bill begin to take hold, there will be three or four open seasons of people who will look at their health care plan and be allowed to make changes in it. They will see the costs go up, and they will say: Wait a minute, what is happening here? The costs are going up, but there are no changes coming from this bill the Senate passed back in 2009—or 2010, if we push it until next year. What is happening?

Well, your costs are going up in anticipation of the costs of this bill that will take hold in January of 2014.

At that point, the anger we are seeing from constituents now will get worse. The anger we are seeing in the e-mails and letters I am receiving now will get more intense, and people will start to say: You mean I am being forced to pay extra premiums in 2010 because the government needs to accumulate cash against the time when these great changes hit us in 2014? When they start writing me that kind of complaint, I will say: That is exactly what I mean. The government is going to start taxing you in 2010, but they are not going to do this program until 2014—at which point, the outcry from constituents will be: Well, let's stop the taxes and let's kill the effective date of 2014.

I am not sure I can predict that with certainty, but I can go back in history and remember the catastrophic bill that was passed with respect to Medicare, and the senior citizens suddenly discovered how much it was costing them. The outcry was so overwhelming that the Congress, within a matter of 6 months of the passage of the bill, repealed the bill. I remember the pictures that appeared in national magazines of Congressmen Rostenkowski, who was at the time the chairman of the Ways and Means Committee, being accosted physically when he went home to Chicago by seniors who would stand in front of his car and not allow him to move, who would sit on the hood of his car to block his way in every conceivable way. The outcry was enormous when they saw this increased cost for something where they did not see a corresponding benefit, and Congress responded to that outcry and repealed that bill.

In this case, there will be a 4-year period for the outcry to build before they start to see the benefits, if, indeed, the bill does confer benefits. There will be a 4-year period with that many open seasons for people to look at their programs and see their premiums go up and see their plans change and see the adjustments made in preparation for this, adjustments they will not want; 4 years in which they will see the statement of the President of the United States, that ''if you like your plan, you don't have to lose it,'' prove not to be the case.

In that 4-year period, it is entirely possible that the outcry from constituents, like the ones who are complaining now, will have tremendously more impact and more force. I hope that is, indeed, the case, if we pass this bill. I hope that in that 4-year period, before we start to see the wonderful things we are being promised from the other side of the aisle come to pass—the increased premiums, the increased taxes, and the increased costs will be with us—the people of this country will rise up and say: We want this bill repealed. They have 4 years in which to do it, 4 years in which to think about it, 4 years in which to experience it.

Why are we rushing to get this done before Christmas when we have 4 years before the thing finally kicks in? Let's take the time to do it right. Let's take the time to listen to our constituents. Let's take the time to listen to the American people who are examining this bill and, by ever-increasing margins, telling us again and again that they do not like it.

We have heard from many people the reactions of the polls. The Quinnipiac Poll made the comment: It is a good thing the Senate is not letting the American people vote on this bill because the American people are against it. We have seen the Gallup Poll show a tremendous swing, as their people are against it. The more they know about it, the less they like it. Yet we are trying to rush it through in the holiday season to get it done before Christmas even though it is 4 years away before all of the wonderful things that are being promised will surface.

Mr. President, I think my constituents have it right. I think those people who belong to AARP who are saying they are going to drop out because of AARP's endorsement are right. I think those physicians who say they are either not members of the AMA or they are going to drop out from the AMA because of the AMA's position are right. And I think if we cram this thing through in a sense of urgency, even though it is 4 years from implementation, we will see an outcry in the intervening 4 years from the American people that will cause Members of the Senate to wish they had taken more time to examine it all, to do it right, and not to panic over pressure from various special interest groups that see ways in which they can profit from this.

The American people, the American physicians, the American patients all see ways in which they will be hurt, and I speak for them, as they say: Slow this down. Do this thing right. Do not panic under pressure of an artificial time deadline.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

IN PRAISE OF WENDY TADA

Mr. KAUFMAN. Mr. President, I rise to speak today about my great Federal employee of the week who works at the Department of Education.

Whenever I enter this hallowed Chamber, I never fail to notice the inspirational words written on each wall above the doors. Above the east door is inscribed the Latin phrase ''Annuit Coeptis,'' or ''Fortune favored Us in Our Beginnings.'' This refers to our Founders' belief that Providence looked kindly upon our Republic during its earliest days.

In that time, ours was mostly an agrarian society. Town life centered on planting seeds and harvesting crops. Children worked alongside their parents in the field, and when it came to their education, homeschooling or learning to read and add in a one-room schoolhouse was the norm.

Thomas Jefferson wrote, some years after his Presidency, that ''Science is more important in a republic than in any other government.'' It was this belief in the importance of knowledge and reason—including political and historical literacy—that led education pioneers such as Horace Mann to promote universal schooling in the early part of the 19th century.

Shortly before the Civil War, access to compulsory and free public education spread across the country as States passed laws inspired by this principle. The Morrill Land-Grant Colleges Act provided for the construction of some of our Nation's greatest colleges and universities in the late 1800s. In the early years of the 20th century, States increased access by expanding free, compulsory education to include high school. The last 60 years saw dramatic advances in this area, with the legal desegregation of schools and the passage of critical legislation such as the Elementary and Secondary Education Act and the Individuals with Disabilities Education Act.

I am proud to have been serving in the Senate earlier this year when we passed the American Recovery and Reinvestment Act. That legislation sent much needed funding to fix schools, make student loans more readily available, and to keep teachers in the classroom. The Recovery Act so far saved over 230 teaching jobs in my home State of Delaware alone.

In 1980, the U.S. Department of Education was created, and its employees have been working tirelessly to make sure students from all 50 States, including Delaware and Rhode Island, receive the same strong support. They oversee the Federal loan programs that enable tens of millions of Americans to afford college and postcollege studies. They help develop policies to ensure that Americans with physical and intellectual disabilities have education programs in their communities and can pursue a full range of opportunities.

Wendy Tada, who has worked at the Department of Education for 9 years, is one of those outstanding employees. When she arrived at the Department in 2000, Wendy already had a great deal of experience working to expand opportunities for rural special needs students in Hawaii and Alaska.

Wendy, who is a lifelong learner herself, holds a bachelor's degree in psychology from Seattle University, a master's in physical therapy from Stanford, and a master's in public health from San Diego State. She also earned a doctorate in developmental psychology from the University of California in San Diego.

Wendy's experience includes working at the State and local levels. She provided physical therapy to disabled students in Washington State, developed an education curriculum for special needs children in Hawaii and its remote Pacific Islands, and evaluated health and education services in Native Alaskan villages.

Wendy has taught college and graduate courses in education and public health at the University of Washington and the University of Hawaii.

Her first job with the Department of Education was as a research analyst in the Office of Special Education Programs. Wendy's talents and experience led to a promotion within a year, when she became Chief of Staff to the Assistant Secretary overseeing that office. She continued as his top adviser when he was appointed to serve as Assistant Secretary for the Office of Vocational and Adult Education. In 2006, Wendy became the Chief of Staff to the Deputy Secretary of Education.

This January, after a brief stint as an education analyst for the Office of Management and Budget, she was asked by the Deputy Secretary of Education to serve as senior adviser for policy and programs.

During her years in the Department, Wendy has been instrumental in developing important regulations and guidance documents relating to IDEA and title I of the ESEA. Today, her time is spent in developing and putting into practice education programs funded by the Recovery Act.

One of the central programs under the Recovery Act is the new Race to the Top Fund. This initiative represents the largest Federal competitive investment in elementary and secondary education in our history. It will offer over $4 billion—that is billion—in grants to States to develop comprehensive education reform plans. This will help all States, including Delaware, save even more teaching jobs and add new resources for schools.

Wendy's work and that of her colleagues throughout the Department of Education continue to benefit American students nationwide. They ensure that all our children are favored in their beginnings so they may pursue the opportunities they deserve. Education is, without a doubt, the most important investment our Nation can make, for its dividends are our future prosperity and global leadership.

I hope my colleagues will join me in honoring Wendy Tada and all the hardworking employees of the Department of Education for their service to this country. Our future is in their hands.

I yield the floor.

The PRESIDING OFFICER. The distinguished Senator from Arizona.

Mr. KYL. Mr. President, I wish to say a few words about the legislation which is pending before us, which is the Omnibus appropriations bill. It is a bill that will substantially add to our national debt and substantially increase spending and I think it is worthwhile to point out some of the features of this bill, since presumably we will be voting on it sometime this weekend.

I would start by pointing out that our national deficit for the past fiscal year now stands at $1.4 trillion. So the fiscal year which just concluded added $1.4 trillion to the national debt. That is the largest deficit we have ever had, by far. It is about three times as much as the largest deficit under the Bush administration. Our current unemployment level is at 10 percent, despite the administration's insistence earlier this year that Congress pass a $1 trillion-plus stimulus package that was supposed to reduce unemployment. The Senate is currently in the middle of a debate on a health care bill that has a 10-year implementation cost of $2.5 trillion. Sometime in the next month we will be forced to raise the Nation's debt ceiling for the second time this year to a level that exceeds the current ceiling of $12.1 trillion.

If all that were not enough, we are now presented with this Omnibus appropriations bill that costs nearly $500 billion more; to be exact, $446.8 billion. This is simply irresponsible. When is it going to end? We are piling spending bill on spending bill and debt on debt. At a time when many Americans are being forced to get by on less, the majority has crafted a bill that uses the government's credit card to increase spending on the six appropriations bills that make up this package—by how much? By 12 percent total.

For perspective, according to the Bureau of Labor Statistics, the consumer price index, the CPI, the measurement of inflation over the past 12 months, was .2 percent. So the cost of living is going up by .2 percent. Yet we are giving these government agencies 12 percent more money for next year. Let me give some examples.

The Transportation-HUD bill receives a 23-percent increase over last year. Has anybody had their income go up by 23 percent over last year? Well, if you are in the Federal Government, you can make it happen. That is not responsible.

How about the State-Foreign Operations bill, a 33-percent increase, a third over last year—a 33-percent increase. Included in that is a 24-percent increase for the State Department's salaries and operations account. That is not responsible.

The Commerce, Justice, and Science bill receives a 12-percent increase over last year. At least that is the average of the six bills in total.

How about earmarks? Well, they are in here, big time. According to Taxpayers for Common Sense, this bill is larded up with 5,224 earmarks—5,224 earmarks—that total $3.8 billion. That is not responsible.

Some examples include $600,000 for a streetscape beautification in California and $300,000 for Carnegie Hall music and education programs in New York City. In the current economic environment, that doesn't seem to be the most responsible use of Federal taxpayer dollars.

If the irresponsible levels of spending were not bad enough, the bill makes a number of significant policy changes as well. Ordinarily, we are not supposed to have policy changes in an appropriations bill, but when you lump them all together in a take-it-or-leave-it form, such as this omnibus, well, if you are the majority, you think you can get away with it. Here are 134 examples.

With respect to the fairness doctrine, this omnibus does not include the fiscal year 2008 ban on Federal funds being used to enforce or implement the so-called fairness doctrine—so nothing to implement or enforce the so-called fairness doctrine.

The bill makes some changes to several longstanding policy provisions contained in the financial services bill and specifically the District of Columbia section dealing with abortion, medical marijuana, needle exchange, domestic partners, and the DC Opportunity Scholarship Program. That program has been enormously popular and enormously successful. Yet this bill provides only enough money—$13.2 million—to allow the currently enrolled students in this popular program, the DC Opportunity Scholarship Program, ultimately leading to the termination of the program. I have met with some of these students and their parents. They are doing very well because of the

environment in which they are finally able to study and learn and be safe. This program is so popular that people have lined up in long queues to take advantage of it. Yet we are going to terminate the program as a result of language in this bill.

Well, it is a cross between irresponsible policy and spending.

The bill reduces funding for the Office of Labor Management standards at the Department of Labor by 10 percent. This is the office that investigates union activity and the use of membership dues. Since fiscal year 1998, it has secured 1,400 convictions, resulting in the return of $106 million in embezzled funds to union workers. So where are our priorities? The only place where we see cuts in this bill are in areas where, in this case, the Department of Labor has been enforcing labor law and getting convictions for embezzlement of workers' funds. This is not an area where we want to cut, unless, of course, you are trying to do the bidding of the labor unions who don't like to be called to account for embezzlement of trust fund moneys of their members.

Well, what is missing from this bill? Despite spending nearly $500 billion and covering 6 of the 10 appropriations bills, this bill is significant for what it does not include: The fiscal year 2010 Defense appropriations bill, arguably the most important bill yet to be acted upon. Just shortly after President Obama announced his surge strategy for Afghanistan, the majority has decided to play politics on the backs of our troops. The majority is holding the Defense bill back from this package so it can be used as a vehicle for other purposes; for example, to increase our Nation's debt ceiling and potentially push through a number of other bills that likely don't have the votes to pass on their own. That is wrong. While our commanders in the field and civilians at the Pentagon wait, our other less-urgent appropriations priorities will receive double-digit spending increases. That is not responsible and it is not right.

Given what I know about this bill—and I haven't had a chance to read it all yet—I would echo my friend in the House, Republican leader JOHN BOEHNER, who requested the President uphold his campaign promise to go through the budget, line by line, and eliminate irresponsible and wasteful spending.

I can assure my colleagues, we will go through this and we will identify those earmarks and we will bring them to the attention of our colleagues, and we will, undoubtedly, because of these spending increases and earmarks and bad policy, attempt to defeat this legislation.

Finally, I wish to make reference to some comments I saw delivered by Dr. Christina Romer, Chair of the White House Council of Economic Advisers, as I was drinking my coffee and watching TV a couple days ago. This was on CNN's ''American Morning'' program on December 8. I was rather startled because she said she was getting rid of the jobs deficit and dealing with the budget deficit, two big problems we inherited and absolutely have to deal with.

Well, it is true, on January 20 of this year when President Obama took office, we had a deficit and we also had a problem with unemployment. The problem is in inferring they are doing something about it, whereas the Bush administration created the problem, I think they create a misimpression. So I asked my staff to get just two numbers. What was the national debt the last day of President Bush's second term and what is it today—or actually December 7 is the date we got the number for, the 322nd day of President Obama's term. In other words, Dr. Christina Romer was saying these are big problems we inherited and we have to deal with them. So how have they dealt with them? Well, it turns out the national debt the last day of President Bush's second term was $10.6 trillion. What is it today, 322 days later? It is $12 trillion. That is some way to fix that problem.

If they are going to complain about the national debt, then get it reduced instead of increased in less than a year—it has gone from $10.6 trillion to $12 trillion; that is $4.5 billion in new debt every single day. These are not my numbers, these are the official statistics of the Bureau of the Public Debt.

The other statistic was unemployment. ''We inherited unemployment.'' That is true. I don't know the average, but I think it is somewhere around 4 or 5 percent in our country. On the last day President Bush was in office, unemployment stood at 7.6 percent. I thought, given the stimulus package, surely we have reduced unemployment. What is the unemployment number today? It is 10 percent—after nearly a year of President Obama's failed $1 trillion stimulus experience.

When Dr. Romer said ''we inherited this problem,'' my immediate reaction is that the President has been in office for a year. What has he done about it? Answer: It has gotten worse. We have added well over $1 trillion to the national debt, and unemployment is now up to 10 percent from 7.6 percent under President Bush.

Some fixing of the problem. I suggest that President Obama and his White House officials and staff stop trying to blame President Bush for everything. If the President has been in office long enough to get the Nobel Peace Prize, presumably he has been in office long enough to do something about the public debt or unemployment.

He has done something about it all right: Unemployment is up from 7.6 percent to 10 percent, and the national debt is up from $10.6 trillion to $12 trillion.

In view of these facts, it doesn't make sense to me to pass a nearly $500 billion omnibus appropriations bill, with departments of this government receiving 26, 30, and 33 percent increases in their budget, when the CPI has only gone up .2 percent this year, and when Americans are scrimping and saving and trying to get by with less. It makes no sense at all.

I hope my colleagues, as we consider this omnibus appropriations bill before us right now, will take these things into consideration before we vote to pile yet more debt on the backs of our taxpaying constituents.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I want to speak for a few minutes on the Labor, Health and Human Services, Education, and Related Agencies appropriations bill. The Senator from Michigan was kind enough to let me do this now, even though she had been on the floor.

I ask unanimous consent that at the end of my comments, the Senator from Michigan be recognized.

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

Mr. HARKIN. Mr. President, as chairman of the subcommittee on Labor, Health and Human Services, Education and Related Agencies, I want to take a few minutes to go over the bill we have before us, the so-called ''minibus.''

I wish in the beginning the Senate could have debated and voted on the Labor-HHS bill individually, rather than having it as part of the so-called minibus. Unfortunately, it is now December. We still have to complete the health care bill and, frankly, we have run out of time.

However, I want to assure my colleagues that the Labor-HHS appropriations bill is a bipartisan bill. We worked closely with Senator COCHRAN and his staff to reflect Democratic and Republican priorities alike. That is the tradition in our subcommittee—one we take very seriously.

In fact, the full Appropriations Committee approved our bill by a vote of 29 to 1. You cannot do much better than that to accommodate the concerns of both parties.

I also want to assure Senators that this is a fiscally responsible bill. Overall, our bill increases discretionary spending by just 2 percent over the fiscal year 2009 Labor-HHS appropriations bill.

With money so tight, we had to be selective about which programs received increases. One high priority is worker protections. Agencies that enforce rules protecting the health, safety, and rights of workers have been seriously shortchanged in recent years. This bill adds $121 million over last year's level and brings staffing levels at the Occupational Safety and Health Administration, the Employee Benefits Administration, and the Employment Standards Administration back to where they were in 2001. This means the agencies will have the resources they need to prevent wage theft and ensure safe workplaces for our Nation's workers.

The bill also includes a 50-percent increase—a total $1.1 billion—to reduce improper payments, fraud, and abuse from mandatory benefit programs, such as unemployment insurance, Medicare, and Social Security. These antifraud, anti-abuse measures could result in over $48 billion in savings and increased revenues over the next 10 years.

Another priority we had was getting people back to work. This bill provides an increase of $72 million, or 43 percent, for nurse training programs, including a new program to train nursing home aides and home health aides.

This bill also provides a major increase—$260 million—for the national service programs. This will boost the number of AmeriCorps members significantly and create a new social innovation fund that will help small nonprofits tackle a host of social programs.

In the area of education, increases are targeted to programs that are designed to reform schools, such as performance-based pay for teachers and principals, charter schools, and a comprehensive new literacy program.

Providing increases, such as the ones I have described, meant making some tough choices. Our bill eliminated 11 duplicative and ineffective programs, and we cut several others. Not everybody will be happy with all of those decisions. I may not be happy with all of them, but we did the best we could, struck compromises, and I stand by the outcome.

I also support the other five bills in this minibus, if I might say that. I worked closely with our colleagues on the Appropriations Committee. I want to particularly thank Senator MURRAY regarding her work to allow fiscal year 2009 Community Development Block Grant funds to be used as a match for other Federal programs. The reason this is important is because many States and local governments were hard hit by both disasters—such as the floods in Iowa—and the poor economy. They would have great difficulty providing Federal match requirements without this modification. I thank Senator MURRAY for putting that in her bill.

I also thank Senator DURBIN for the inclusion of a provision regarding auto dealers. In my State, there are a number of decisions that were made by General Motors to close down certain dealerships that met the criteria set down by General Motors for staying in business. I hope this provision that Senator DURBIN put in will allow for needed fairness for a number of these family businesses.

Again, I believe the package of bills we have before us is fiscally responsible. They move our country in the right direction, and I hope the Senate will approve them as soon as possible so we can send them to the President.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, before my good friend from Iowa leaves the floor, I thank him for his wonderful leadership on the health care reform bill, on the appropriations that he chaired—formerly on Agriculture. It has been a pleasure to partner with him on so many things.

Mr. President, I ask unanimous consent that I be allowed to speak as in morning business for up to 20 minutes.

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

Ms. STABENOW. Mr. President, I want to talk about health care. I have to say that if 20 percent of what was being said by our Republicans friends was true about this bill, I could not vote for it either.

I keep hearing things described that have no relationship to the reality of the bill that I helped to write in the Finance Committee, or my friends helped to write in the HELP Committee or the bill that is on the floor now. I see all kinds of comments that, frankly, concern me because I don't see them reflected in the reality of the legislation in front of us.

I encourage people to take the opportunity to read the bill or the summaries. For the people in Michigan, we have had it up on our Web site, and we have had every bill, as it is introduced and passed, on the Web site, so people will have an opportunity to look at the information available.

I do know this: What we have been hearing from our colleagues is not good enough, when we think about the fact that we had a Congress and a White House for 6 out of the last 8 years that was controlled the by Republican Party and yet nothing was done. Proposals have come forward now about all these things that should be done. But they weren't done when they were in charge. What we saw was a lot of tax cuts for the wealthy people and a lot of no-bid contracts for friends of people in the administration. We saw a lot of things that didn't affect people in my State very positively and didn't help the working people in my great State of Michigan.

But now, as we are trying to move forward and do something for people, for small businesses and large businesses, and bring down costs and provide health care for people, there are all kinds of suggestions about why we should wait and do it over. What I heard in committee and what I am hearing now on the floor, as a proposal—because we don't have a Republican bill in front of us or one that has been offered—is this: Wait, wait, wait. We don't need to do this. That doesn't have to be done right now. There is no sense of urgency. We should wait, wait, wait.

That is what we hear. We hear that business as usual for the insurance companies is OK. Let them decide what is covered—if you can find insurance—and how much it should cost, whether or not they are going to be able to provide a test for you or an operation for you. That is OK. Let the insurance companies continue to be the ones between you and your doctor. That is what we have seen over and over. We saw it in committee. Every time we were trying to lower costs for families and small businesses, they were on the side of helping the insurance companies. They were willing to take tax cuts we put in the bill, and they offered amendment after amendment that would have had higher costs for middle-class families and small businesses, in order to help the insurance industry.

I will share a few stories from people who have become part of our health care people's lobby through my Web site, who have been willing to share stories.

David is from Sutton's Bay, which is a beautiful part of Michigan. We would love to have you come visit. It is a gorgeous part right on the water. David says:

> I'm a 61-year-old cancer survivor with diabetes and high blood pressure. I am self-employed, and lately, uninsured. I worked all my life to build a stake here in farm country and almost lost it last fall to foreclosure because of a medical emergency. This farm is all I have . . . the savings and cash are gone. I continue to work with no retirement in sight. I have put everything I had for retirement into my farm. Please, help me keep it.

I know that David is not saying wait, wait, wait. He wants us to act, and to act now, on something that will be meaningful and makes sense to bring down costs, to give him a chance to find affordable insurance that doesn't bankrupt him and his family.

I want to share also another story from Jeff from Rockford, MI:

> It has been over five years since death stared me down. I was diagnosed with testicular cancer. Losing my job to a layoff, mortgage to pay, among other things—and my options were minuscule. I had no insurance then because there was none that I could afford.
>
> I thank God and the staff at Grand Rapids Spectrum Health for my life today. Unfortunately, I am still $25,000 in debt because of lack of coverage.
>
> I served in the Marines from 1984–1988. One of their mottos is, ''We take care of our own.'' Imagine what this country would be like if we all thought like that.

Jeff is right. We are in this together and, just as we have dramatically increased our support for our veterans and their health care, we need to make sure we are taking care of our own American families and American businesses.

Wait, wait, wait? I don't think so. I don't think that is what Jeff is asking us to do.

Jennifer from Hollow, MI:

> I am married and have one beautiful little girl. But about 6 months ago, my husband's work informed us they would no longer be able to carry health insurance for their workers.

A very common story, having to choose between keeping people employed and paying for health care.

> We could have gone on COBRA but it would have cost double what we were paying and we couldn't meet that cost.

Mr. President, as you know, we have worked to lower the cost of COBRA, and we hope to be able to continue that lower cost in legislation that will be coming up shortly. But it is still very expensive.

We are lucky because Michigan has a program for children, so we didn't have to worry about our daughter's coverage. When we went to look for insurance for my husband and me, the prices were steep or we were denied because of my preexisting condition.

That is one of the things we are going to change.

Right now going to the doctor is next to impossible, but to see a specialist is like asking for the Moon. We know that we are highly blessed. My husband has a job. That is more than a lot of people have. We just want affordable health insurance, and we don't mind paying for it. It just doesn't seem like too much to ask, does it?

No, Jennifer, it is not too much to ask, and that is what we are all about. We are all about putting together a plan—and that is what is in front of us—that will lower costs, that will save lives, save Medicare, that will focus on making sure each American has a health care bill of rights, has protections they know will allow them to make sure their health insurance will be available if they pay for it; that they cannot get dropped because of a technicality; that if they have a preexisting condition, they can still find affordable insurance; that there will no longer be lifetime caps on insurance policies; that we will allow our young people to stay on mom's or dad's insurance until age 26.

We have a number of changes we are making for people in the insurance exchange, for policies that take effect after the effective date of this act, and it is about making sure people have affordable insurance and they are getting what they are paying for. That is what this is about.

What happens if we do nothing—if we do nothing; if we wait, wait, wait, like the Republicans are saying? Every single day 14,000 Americans lose their health insurance; 14,000 people got up today with health insurance and they will go to bed without it. That happens every single day.

Insurance rates are going to double in the next few years, by 2016. Business costs are going to double. Increased premiums are going to cost us, it is expected, 3.5 million more jobs. I don't know about any of my colleagues, but we cannot afford to lose any more jobs in Michigan. Health care is directly related to jobs and our international competitiveness.

We know incomes of families will be reduced. We know every 5,000 homes will be foreclosed as a result of a health crisis, and 62 percent of the bankruptcies are as a result of a health care crisis.

Wait, like our Republican colleagues say? No, we cannot wait. The families, the people I talked about and read their stories, they cannot wait. Families cannot wait. Businesses cannot wait. Small businesses that cannot find insurance cannot wait. Large businesses that are finding themselves in difficult situations, considering pulling up shop and going to another country because of lower health care costs cannot wait.

People expect us to solve this problem. They expect us to come together and work together, without all the stalling and the objections and the partisan politics. They expect us to come together and solve what is a huge American problem by bringing down costs and creating access to affordable health care where people know that the insurance company will not be the one that is standing between them and their doctor.

This is about saving lives, saving money, saving Medicare. Mr. President, 45,000 people will lose their lives in the coming year. And 45,000 families will have one less chair or an empty chair at the holiday dinners that are coming up because 45,000 people could not find affordable insurance in this country—Americans, in America.

Saving money—this is about making sure small businesses get the tax cuts they need to help them buy insurance, to make sure that families who are buying through the new insurance pool get the tax cuts they need to afford to buy insurance.

This is about making sure large businesses begin to see costs come down over time because when they are providing insurance already, they are not going to pay the extra costs of folks walking into an emergency room uninsured who are treated and then the costs get rolled over on to everybody with insurance.

We as a country are going to save dollars, save money over time for taxpayers and strengthen Medicare to bring down costs.

And, yes, we are going to save Medicare. We are going to lengthen the Medicare trust fund solvency. We are going to make sure overpayments to for-profit insurance companies are reined in so that the majority of seniors do not see their premiums go up under Medicare to pay for those excess profits.

We are going to make sure we are closing that gap in coverage for prescription drugs that has now been called the doughnut hole, where too many seniors or people with disabilities fall into that hole, cannot afford their medicine, and are not able to get the care they need.

We are going to make sure preventive care does not have an extra cost of a copay or deduction because we know it saves money and saves lives. Under Medicare, we are going to make sure that is there as well.

That is what this is about. It is not about waiting. It is not about all the other stuff we have heard that are scare tactics. This is about tackling and solving a problem for the American people that we cannot afford to wait to do any longer.

Coming from Michigan, I have to say everything I do, everything I care about is about saving jobs. We know in addition, we truly are saving jobs. We are saving jobs for our large employers right now that provide insurance, have been doing the right thing for years but have seen their costs go up 10 percent, 20 percent, 30 percent every year and cannot sustain it anymore. They are cutting health care benefits, raising premiums, or laying people off because they cannot afford it.

We know our small employers under our package will save 25 percent. I believe we are going to be doing even more for small businesses.

We have tax credits to help companies, and, as I indicated before, our plan is going to save 3.5 million jobs that would otherwise be lost because of the increased health care costs that cause employees to be let go or companies to move overseas.

We are talking about saving lives, saving money, saving Medicare. We are talking about saving jobs.

What we are not talking about is waiting. We are not talking about stall tactics or politics. We are way beyond that. I understand there is a big strategy to make sure the President of the United States is not successful. There is a big strategy to make sure we are not successful in the Senate. We have seen more filibusters and more objections than ever before. The vast majority of the days we have been in session—I believe it is 39 weeks now—all but 4 of those we have seen filibusters. It has never been done before—filibusters and objections over and over again.

We are committed to getting beyond that and focusing on the reality of what is happening in people's lives. People are waiting for us to step up and to solve this problem and to give them the ability to have access to affordable health insurance for themselves and their families.

We are not proposing something radical. We are proposing that we fill in the gaps for the folks who do not have insurance today, most of whom are in a small business, most of whom are working maybe one, two, three part-time jobs but they are working and they don't have access to health insurance, or they are self-employed, as the gentleman I talked about, David, in Suttons Bay, maybe a farmer, maybe a realtor, maybe the next Bill Gates in their garage coming up with the next great invention. They don't have access to the same big insurance pool that a big business has to bring down costs.

What we are talking about for those folks who are working or have recently been laid off and cannot find insurance is giving them a way, a competitive way to buy insurance from an insurance pool.

I cannot imagine a more important Christmas present to give to American families than the ability to know going forward that when they lose their job, they are not going to lose their health

insurance; that they have an opportunity, a way to get affordable insurance, and that we have come together as a Senate to focus on saving lives, saving money, and saving Medicare.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. BEGICH). The Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, I would love to interject a question to the distinguished Senator from Michigan.

We are in a situation in which the other side is repeatedly coming to the Senate floor to ask us to delay, to stop, to slow down, to start over. I am curious, as somebody who has watched this debate very closely, what the Senator from Michigan thinks about where we would be if we acceded to that wish? Bearing in mind that one of the sort of ideological firebrands who seems to be leading a measure of the debate on the other side has indicated this is not about health care and people; this is about giving President Obama a Waterloo; this is about creating a political defeat for the President of the United States on their side; it has nothing to do with health care; it is entirely about creating a defeat for this new President; when, in the face of all the obstruction the distinguished Senator from Michigan described so eloquently, this recordbreaking, ''unprecedented in the history of the Senate'' obstruction we are seeing, the person whom I think right now seems to characterize the leadership of the radicalized rightwing and is running the Republican Party, Rush Limbaugh, is telling the other side they have not been obstructive enough.

So if we were to go back, start all over, and reach out our hands again to our friends on the Republican side, is there any reason to believe that we would not be just as rebuffed going forward as we have been in the long arduous process of negotiation and hearing and public meeting and all of the work that has taken us to this point right now?

Ms. STABENOW. Mr. President, I thank my friend from Rhode Island for the question and for his advocacy and understanding of how we bring down costs and what we should be doing in so many areas for families and for businesses in the country.

I will just say that we have, first of all, attempted to get something done for years. In the last couple of years, reaching out to Republicans in an unprecedented way, our distinguished chairman of the Finance Committee, as everyone knows, went to unparalleled lengths in reaching out and spending months and months putting together a work group of three Democrats and three Republicans to work in good faith to get something done.

We have accepted Republican ideas. I know on the HELP Committee there were many amendments accepted from Republican colleagues. We have continued to reach out and look for ways to work together.

But what we are seeing is a lack of desire to work together and more than just a lack of desire, as the Senator indicated, but simply to attempt to embarrass the President of the United States, to stop him from being successful, and to stop us politically, when the reality is very serious. This is not about a President. We have had 100 years of Presidents trying to do this. This is not a particular Senate. We have had Senates for years that have been trying to do this. This is about when are we going to get beyond all this? When are we going to actually get beyond this and focus on the reality of what is going on in people's lives, what is going on in every small business that is trying to figure out how to pay the bills and hold it together or every manufacturer in my great State that is trying to figure out how they are going to hold it together. At one point, the American people will have every right to say to us: When are you guys going to get beyond this stuff?

The good news is, we have a President who has said now is when we are going to put it behind us and the Senate has said now is the time and we will work in good faith with anyone who wants to work with us. But we will not wait, which is what we are being asked to do—wait until another time, when 45,000 more people will have died next year, when another 5,000 people a day will have lost their homes to foreclosure.

Mr. WHITEHOUSE. If we were to wait, does the Senator think there is any likelihood people on the other side would suddenly want to cooperate with President Obama and not hand him a defeat? If Rush Limbaugh would say: OK, Republicans in the Senate, go ahead, work with the Democrats now; don't just be the party of obstruction and delay but try to work cooperatively for the American people, does the Senator think there is any likelihood of that happening?

Ms. STABENOW. I would like to think there would be a likelihood of that happening, but I can't imagine it. Frankly, and I think unfortunately, they view it in their self-interest, whether it is a business decision, as a radio host, or whether it is a decision of the other party. I appreciate the fact that it is hard to lose elections. We have all been in those situations. I appreciate the fact that folks don't want to be in the minority. Most of us have been in that situation. So I appreciate that. But I think all of us were hoping this year, with two wars, with the deficit we have, with the challenge on health care, with the need to create jobs, and with the financial crisis we are in, that somehow it would be different for a while.

I would ask my colleague if he had the same sense of hope coming in; that this year maybe there would be a moratorium on the partisanship; that we could actually come together in the interest of the country and solve problems before going back to the elections. I would ask my friend if he was as surprised as I was that there was not only no stopping after the election but that the same folks who led things during the election are leading them right here on the floor.

Mr. WHITEHOUSE. I share the disappointment of the Senator from Michigan; that the promise and the outreached hands have been rejected and rebuffed; that this place has become so bitterly partisan. This is my first time in the Senate with a Democratic President, and I have been surprised at the tone of the debate, at the lack of truth of a great many of the arguments, of the very apparent motivation.

I have spoken to members of our caucus who I think are probably viewed as some of the most moderate when it comes to seeking bipartisanship, who are calm and respected Members of the Senate and who have been here a long time, and I have asked them how this compares to their long years of experience in the Senate. One of them said he has literally never seen anything like it in all the years he has been in the Senate. He has never seen anything like it. They are always on message, he said, but I have never seen them so off truth.

I think it is regrettable, but if your mission is to destroy a strong and important piece of legislation, not because it is bad legislation but because you can't stand having this new President win a political victory, are you going to go out and disclose that is your motivation? No, you are going to come up with a bunch of other cockamamie arguments to paper that over. You will talk about death panels and you will go through all the nonsense we have seen and it is regrettable.

Ms. STABENOW. If I might interject with my friend, I have been handed a note that says, in fact, there have been over 150 amendments offered by Republicans, and so our attempts have been ongoing to reach out.

Mr. WHITEHOUSE. I think those were the Republican amendments that were accepted into the HELP Committee bill. In fact, I think there were 161, if I remember correctly from my time sitting on the committee. We took Republican amendment after Republican amendment after Republican amendment trying to reach out to them.

Ms. STABENOW. So we have over 300 pages of the bill which contain Republican amendments, and that is fine. There is no ownership in the sense of who has the better ideas. In fact, what I find interesting is the insurance exchange we have in the bill for small businesses—which is at the heart of coverage of small businesses and individuals—has been offered by Republicans and Democrats. I believe distinguished former Senator Bob Dole offered some form of an exchange back during the debate when President Clinton was in office.

So we are not trying to claim a corner on ideas. There are many ideas that have been available and talked about for years. It is a matter of having the will, the commitment to actually do the hard work people expect us to do in order to get this done. I think that is what is so important about this time, when the average family is finding themselves unraveling, with not knowing if their job is going to continue to be available or if there will be a cut in wages. They are paying more out of pocket for everything under the Sun and then worrying if the employer is thinking: Well, you can have your job or your health insurance because the employer can't keep both going.

The fact is, we have lost so many middle-class jobs—and I will spend another time talking about the loss of manufacturing jobs in this country. We have lost a lot of our middle class in terms of good-paying jobs. So people are now saying: Wait a minute, just being the party of no, that is not going to be enough. That is not good enough—just saying no for political reasons. That is not enough. We want to know what you are going to say yes to. We want to know how you are going to work together. We want to know how are you going to actually solve a problem.

When someone such as Joe, from Rockford, MI, says he served in the Marines for 4 years and their motto is: ''We take care of our own,'' my question is: When are we going to come together and take care of our own Americans? I don't mean literally taking care of every person but creating opportunity for people, creating the climate for people to have a job, to have health insurance, to send the kids to college, to be able to afford to keep their lights on, and to be able to know that their country is on their side. That is what this is about. They do not want us to wait more, they want us to move quickly—move quickly on health care and jobs and all the other issues that are so important to their families.

So I thank my friend from Rhode Island for joining me, because there is a sense of urgency that people have, and we need to have that sense of urgency to get things done—to work together and to get things done. Frankly, one of the things our colleagues on the other side of the aisle have successfully done is united our caucus in its determination to not let this kind of stalling and objections and tactics, which are slowing things down, stop us from actually solving a huge problem that has gone too long unsolved for the American people.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Mr. President, we are considering the omnibus bill. Once again, I have to say that we are heading recklessly, at a high rate of speed, toward the most reckless spending this Nation has ever seen. We saw some big spending during World War II but nothing like this, in the kind of environment we are in today. Plus, then we had the whole Nation working to win that life-and-death struggle.

I will just say a few things about this omnibus bill. First, I don't think any of us should support it. Why? It is unacceptable. Why? It is the kind of spending that has caused the American people to be outraged and to go out in the streets. People told me they had never been to a rally before in their lives, but they went out because they are afraid for their country.

Look at the package of spending that is in this legislation—the Commerce, Justice, and Science bill has been cobbled together with the others. There are 6 of the 13 appropriations bills all packaged together into 1 to see if they can't ram it through during the last days before Christmas so nobody will have the gumption to cause a fuss about it and so we can just get this done. What is it that is contained in the legislation that causes such angst on my part and on the part of others? I will explain it for you.

Here are the numbers. The Commerce, Justice, Science appropriations bill contains $64 billion in spending. The percent of growth over last year's spending is 12 percent. Just to recall for my colleagues, if you know the rule of seven, which you learn in accounting: at a 7-percent growth rate—or if you have an interest rate of 7 percent—your money will double in value in 10 years. Here we have a 12-percent increase. That means the expenditure line of Commerce, Justice, and Science increases at 12 percent, which would double that whole amount in about 7 years. Do you think that is what the American people want? This does not count the stimulus package we passed earlier this year. My wife says: Quit saying we passed, when you voted against it. I didn't vote for it. It was $800 billion, and $15 billion went into Commerce, Justice, and Science appropriations. So we go from $64 billion in this bill and add $15 billion on top of that amount, which is already being spent.

What about a second one—financial services. It has a 7-percent increase. The rate of inflation is what, 1 percent? On top of this bill, we add about a $7 billion infusion in financial services from the stimulus package. Last year, the spending was $22 billion; this year, it is $24 billion. Add $6.9 billion on top of that and you have about $31 billion, which is a massive increase.

Labor, HHS, and Education also increased at 7 percent, and it received $72 billion extra from the stimulus package. I am not counting the stimulus when I say it is a 7-percent increase. I am talking about the baseline budget. Military Construction and Veterans Affairs is oddly the lowest. It only received a 5-percent raise. Well, 5 percent is still a big increase when the inflation rate is below 2, and it received $4 billion from the stimulus, which is not much. The stimulus gave very little to military matters.

What about the State Department and Foreign Operations? How much did that budget line increase over last year? Thirty-three percent. We don't have to increase State and Foreign Operations 33 percent. This is beyond a reasonable amount by any stretch of the imagination, and it also received an increase in the stimulus package.

What about Transportation and Housing and Urban Development? What kind of increase did they get in this year's budget, in a time when the American people are having to cut their budgets, when they try to save more than they ever saved before, trying to find work if they or family members are losing jobs, when they are not getting overtime like they did before, when other things are tightening them up and the fear of unemployment is out there; what does Transportation and HUD get in the baseline budget? Not counting the stimulus money: 23 percent increase. With a 23-percent increase you double the whole Transportation-HUD budget in 4 years. This is not responsible.

By the way, the baseline Transportation-HUD budget in 2009 was $54 billion. It was $54 billion, and the stimulus package added $61.8 billion on top of that.

The omnibus bill in all of the spending lines amounts to an increase of 12 percent. This is unsustainable, and the 12 percent does not include the huge amount of money that was funded through the stimulus package.

I see my colleague here, one of our stalwart Members of this Senate. I will yield to him, but I just want to be on record saying I would love to vote for these bills. I voted for many of these funding bills in years past, but I am not going to vote for a package that increases spending of the Federal Government at 12 percent when the average American is lucky to have a job and inflation in this country is 1 or 2 percent. This makes no sense to me.

Remember, this spending is in addition to the amount of money approved in the stimulus package—$800 billion.

If you would like to know how much money $800 billion amounts to, the general fund budget in my State of Alabama—we are an average size State—is less than $2 billion. The entire total spending of these six bills in this omnibus package is $445 billion, and we spent in February—this Congress approved without my support $800 billion extra to try to stimulate the economy. Unfortunately, it has been frittered away without the kind of impact we need.

I am worried what we are doing. I appreciate having this opportunity to share those comments, and I will speak more about it in the future.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I appreciate my colleague's great remarks. I rise today to discuss an important aspect of this multifaceted health care

reform bill that is now pending on the Senate floor. It is tax increases and who will bear the burden of those tax increases. I have actually heard some stand on the Senate floor and say there are tax reductions. Who are they kidding? The gargantuan piece of legislation laying before us provides plenty of fodder for debate and discussion. This debate and discussion is taking place all over the country among Americans everywhere: over the family breakfast table, during breaks at work around the water cooler, in corporate boardrooms, and bowling alleys, and during Christmas shopping trips.

Of course, right here in the Senate we have already had many hours of debate about the health care bill, with many more likely to come. As one peruses the 2,074 pages that comprise the Patient Protection and Affordable Care Act—this bill—it quickly becomes obvious that this bill encompasses many topics and touches on a comprehensive array of issues dealing with our health care system.

However, it is not until near the very end of the bill, starting on page 1,979, that we find title IX, which deals with revenue offset provisions. Perhaps it is because this title is near the end of this seemingly endless bill that we have heard relatively little discussion about the new taxes it creates or perhaps it is because the tax title is relatively short, a mere 67 pages.

No matter the reason, I believe it is vital that the American people understand something about these new taxes before we are asked to vote on this legislation, this gargantuan legislation.

Before I get into the specifics of the new taxes and tax increases in this bill, I need to inform my Utahns and Americans everywhere that they are being sold a bill of goods when it comes to these taxes.

Based on what President Obama promised during his campaign last year, every individual American taxpayer earning less than $200,000 per year, and every family making less than $250,000 per year is justified in believing that this health care bill, which has been endorsed by the President, would not raise their taxes. Here is the direct quote from candidate Barack Obama in New Hampshire on September 12, 2008:

> I can make a firm pledge. Under my plan no family making less than $250,000 a year will see any form of tax increase.

Unfortunately, this bill places the cost of health care reform squarely on the backs of the taxpayers and mostly on the 98 percent of Americans the President promised to protect from new taxes. That is what it said. President Obama's exact words were:

> I can make a firm pledge. Under my plan, no family making less than $250,000 a year will see any form of tax increase.

The President went on to promise:

> Not your income tax, not your payroll tax, not your capital gains taxes, not any of your taxes.

However, when one looks at the list of revenue offsets beginning on page 1,979, we see all but 5 of the 14 revenue raisers included there would hit families making less than $250,000.

There is a cornucopia of new taxes on middle-income Americans in this legislation: a limitation on itemized medical expense deductions for medical expenses; an excise tax on the high-cost health insurance plans; a new tax on medical devices such as wheelchairs, breast pumps, and syringes used by diabetics for insulin injections; a limit on contributions to flexible spending accounts; an increase on the penalty for unqualified distributions from a health savings account; an increase in the payroll tax, and on and on.

Look at all these taxes: itemized medical expense deduction, fees on drug manufacturers, high-cost plan tax—by the way those are passed on to you and me and every other consumer, most of whom are less than $250,000-a-year earners—fees on health insurers, nonqualified HSA distribution from 10 percent to 20 percent, fees on medical device manufacturers, fees on FSAs—a $2,500 cap on FSAs—people who have suffered from disabilities and other problems, they can't live with that kind of cap—and an individual mandate penalty excise tax, all of those. That is just mentioning a few of them. It goes on and on.

Some of these would directly hit many taxpayers who make less than $200,000, such as this 5 percent excise tax on cosmetic surgery, while others would in the form of higher fees and penalties that would ultimately be passed on to the consumer.

This is certainly the indication with the new ''industry fees'' that would be assessed on several sectors of the health care industry.

Who do they think is going to pay for those? It is you and me and everybody else. Look at this chart, the biggest single tax increase in this health care bill is also one of the most insidious. This is the 40-percent excise tax on high-cost insurance.

By 2019, 88 percent, or $30.5 billion will be borne by individual taxpayers. Eighty-four percent of those will be individuals who make less than $200,000 or families who make less than $250,000. That is according to the Joint Committee on Taxation, upon which I sit. It is a nonpartisan committee.

This is the 40-percent excise tax on health insurance coverage that exceeds $8,500 for single families or $23,500 for families.

The unions in this country are going crazy over that, and with good reason.

The proponents of this idea tell us it is necessary in order to ''bend the cost curve'' downward and get the cost of health care under control. However, in reality, this is simply a bastardized version of the concept that might have been effective in discouraging employees from bargaining for too much insurance because it is a tax-free benefit; that is, for corporations that provide it, a cap on the value of tax-free, employer-provided health insurance.

The original concept, which was discussed at length in the finance committee earlier in the process of developing health care reform legislation this year, has merit if done correctly. By providing a direct disincentive to the very individuals who would suffer the tax increase, this original idea would have discouraged purchasing or bargaining for higher cost insurance simply because of the tax benefit.

However, this bill and the one approved by the Finance Committee does not take this route. Instead, it takes the cowardly approach and applies the tax increase at the insurer level.

Why is this a bad idea? For one thing, the tax increase occurs at a level two steps removed from the individual employee, which is where the decision to buy a less costly plan is made. Rather, the tax is assessed on the insurance company which has no choice but to pass the cost of the tax on to the employer and the employee who, together, pay the cost of the policy.

Instead of providing a disincentive for purchasing more health insurance than is necessary, applying the tax at the insurer level simply increases the cost of insurance without the employer and employee necessarily even knowing why the cost has gone up.

You wonder why insurance costs go up?

So for the sake of avoiding what appears to be a direct tax increase on workers, this approach loses the benefit of the original idea of bending down the cost curve by providing a disincentive. But make no mistake, this increased cost of these insurance plans will be passed on to the employees.

''Forty percent excise tax on high-cost insurance''—which most people will have. This is not even—

> . . . by 2019, 88 percent or $30.5 billion will be borne by individual taxpayers; 84 percent of those will be individuals who make less than $200,000 or families who make less than $250,000. The Joint Tax Committee.

My gosh, when does it end?

Moreover this tax burden would not be just on those whom the President says he wants to target for tax increases, those making over $200,000 per year as individuals or $250,000 per year for families. Far from it.

Data from the staff of the Joint Committee on Taxation showed that only 16 percent of the $30.5 billion borne by individual taxpayers in 2019 would be paid by those making over $200,000 per year. This means that 84 percent or almost $26 billion for this 1 year only would be paid by those whom the President promised to protect against tax increases.

Unfortunately, the excise tax on high-cost insurance policies is not the only way the health care bill would increase the cost of health insurance. To add insult to injury, the bill also includes a $6 billion annual fee assessed on providers of health insurance.

I have heard the other side just condemn health insurers, day in and day out. Yet they are adding all these costs

to the health insurers that have to pass them on to the individual citizens, or insurees.

As I understand it, the rationale behind this misguided idea is that health insurance companies will be enjoying a windfall from this bill in that millions of new customers will become insured for the first time. Therefore, the reasoning goes, the health insurance industry will be earning billions of dollars that they would not have otherwise made, all because of the beneficial aspects of this health reform bill.

Therefore, since these companies will be reaping all of this extra profit, why should we not tax them on this windfall in the form of this annual fee as though those costs are not going to be passed on? This is a bad idea on so many levels. First, it assumes that the insurance companies will actually be gaining all of these new customers. Secondly, it assumes that the insurance companies will be making money from these new customers if they indeed gain them. Keep in mind, they are talking now in the back rooms. Nobody knows what they have concluded. They are talking about putting people into Medicare from 55 years old on, where today you have to be 65 years of age to be able to qualify for Medicare. Now they want to do that at 55. What does that mean? That means the sickest of the sick will go into Medicare. People are going to push them out of regular policies and others will go into Medicare, so these insurance companies aren't going to make all the money the Democrats say they are.

The third assumption is the most troubling. That is that it would be the insurance companies themselves that would bear the burden of these fees. These are all dangerous assumptions. The third one is downright fallacious. It assumes that corporations suffer the incidence of taxation. As anyone with a modicum of economic training knows, corporations do not bear the burden of taxes, people do. Specifically, it is the people who work for the corporation, who own the corporation, and who are the customers of the corporation who ultimately pay the tax. They are passed right on to the people. This is not the only dangerous new excise tax in this bill. We have a whole passel of them. A new excise tax on health insurance providers. Look at this, excise taxes in the health care bill, excise tax on health insurance providers, new tax on pharmaceuticals, a new tax on medical devices, a new tax on high-cost insurance plans, and a new tax on cosmetic surgery. In the case of competitive markets, an excise tax is generally borne by consumers in the form of higher prices in the long term. At least this is what the staff of the Joint Committee on Taxation said to me in a letter on these insurance industry fees, dated October 28, 2009. Why in the world would we want to add a fee to the health insurance industry when we know it will be passed right on to consumers of the health insurance in the form of higher insurance costs? That means you and me. That means the employee. That means the person who bears the burden. I thought the purpose of this health reform bill was to rein in health care costs.

How much does this so-called health care reform bill harm taxpayers and violate President Obama's promise not to raise taxes on the middle class? Let me tell you about one of the most egregious tax increases in this bill. I have always believed that one of the major purposes of health care reform is to lower the cost of medical expenses to American families and especially to vulnerable American families. Therefore, it makes no sense to me that this bill should include this next tax increase which would largely hit the sickest Americans. This proposal would increase the threshold for deducting medical expenses from today's level of 7.5 percent to 10 percent of adjusted gross income. This seemingly small change is projected by the Joint Committee on Taxation to cost taxpayers over $15 billion over 10 years. Which taxpayers would suffer this tax increase? The ones earning more than $250,000 per year that President Obama pledged would be the only Americans to be saddled with a tax hike under his administration? Hardly. Of the many millions of families affected by this change, only a few thousand have incomes over $200,000. Think about that. The vast majority of the victims of this tax hit would be below that figure, with many of them being far from wealthy. In fact, a high percentage of the taxpayers affected by this change make less than $75,000 per year.

Look at this. If your income equals $100,000, then you need to incur $10,000 worth of medical expenses before you become eligible for the deduction. Millions of taxpayers making less than $200,000 will be affected. The deduction for medical expenses has been in the Tax Code for decades. Its purpose is to provide relief to Americans who face catastrophic medical expenses in relation to the size of their income. It is designed so that an average or usual amount of health care costs will not trigger the relief. Like I say, a family earning $100,000 this year would have to have medical expenses exceeding $7,500 before the deduction kicks in. This does not count what insurance pays but only what the family would fork over in out-of-pocket costs.

Even for those with the most basic health insurance, 7.5 percent of family income spent for medical expenses is a large amount. In many cases, this much medical cost relative to income is caused by chronic health conditions or serious accidents or injuries, and this is exactly the point. The current tax law rightly says that if a family has to pay catastrophic or near catastrophic amounts for health care during the year, relief is available. By design this deduction is there only for those who need it. So the big question is: Why we would want to increase taxes on those with already high medical expenses by making it tougher for them to get relief from catastrophic medical expenses. But the real conundrum is why would we do this as part of a bill that is supposed to rein in health care costs.

It is no wonder my fellow Utahns and Americans everywhere are questioning the wisdom of this bill. As with so many other features of this so-called health reform plan, this doesn't make sense.

There is much more I want to say about the tax increases in this bill. American taxpayers need to know the truth about what is about to hit them, if the majority has its way. I have not yet mentioned the new industry fee on medical device companies. Because my home State of Utah has many such companies, I plan to address this new fee in a separate floor statement as this debate progresses.

Let me summarize by reminding my colleagues that the tax increases in this bill fly in the face of the promises made by the President, the leader of the majority party in Congress who has explicitly endorsed this legislation. The staff of the Joint Committee on Taxation recently conducted a distributional analysis of how four of these tax increase provisions affect American taxpayers. Under that analysis, in 2019, individuals making over $75,000 and families making over $75,000 will see their taxes increase under this bill. That is equal to 42 million middle-income taxpayers. Think about that: 42 million middle-income taxpayers all making less than $200,000 per year and all of them, told by the President that they would be protected from tax increases, will be hit and hit hard by this bill. This is after taking into account the tax effects of the advanced refundable tax credit for health insurance.

Think about this: Millions more middle-income taxpayers will be hit by indirect tax increases from the health industry segment fees included in this bill. There is no question that these fees and other excise taxes will be passed through to the individuals who are consumers of the health care products that are being passed. As we debate this health care bill, it is imperative that the American people know what is in the legislation and how it will affect them. It would be a travesty for us to vote on this before these things are fully understood and debated. This is one of those few bills that come along only once in a generation or so. It is one of those bills that has the potential to change our country forever, for good or bad. In this case, it is not for good.

The tax increases in this bill are unprecedented in many ways and not well thought out. They will have a devastating effect on the people the President has promised to protect. The tax increase aspect alone of this leviathan is enough to demand its defeat here in the Senate. But there are so many more ill-advised provisions in the other 2,007 pages as well.

I urge my colleagues to take a good and honest look at these tax increases and make sure they are ready to face the vast majority of their unsuspecting constituents once they discover what has been done to them with this bill, should it pass.

I am very concerned about this bill. The American people are very concerned about this bill. Polls show they don't support this bill. I can't believe my colleagues on the other side are trying to present it as though it is a tax deduction bill when, in fact, it raises taxes in billions and billions of dollars, most of which go to the middle class or lower in transferred payments, and causes other problems added to their woes in health care and their very lives, as we go through all of our lives here in the United States. I am very concerned about it. I think everybody ought to be concerned about it. This is one-sixth of the American economy. If we can't get 75 to 80 votes in a bipartisan way, you know it is a lousy bill. This is a lousy bill. From what I have heard of the one that even Democrats don't know what form it will be in, it is going to be even more lousy.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, pending before us now is an omnibus bill which contains six different appropriations bills. It was not our intention to call this omnibus bill but to call each one of the appropriation bills. Unfortunately, it has been impossible to reach that goal because of a strategy that has been employed by the Republican side of the aisle to slow down any debate on any topic as much as possible, to challenge us with filibusters and force cloture votes and make the Senate go into interminable quorum calls. So many times we have called bills that came out of the Appropriations Committee with overwhelmingly positive votes only to run into roadblocks on the floor. And then after weeks and weeks and weeks of procedural problems tossed our way by the Republican side of the aisle, the bill is finally called and passes by an overwhelming margin. The strategy is clear.

It is as clear on the health care bill as it is on the appropriations bills that the Republican side of the aisle doesn't want us to complete. So we are attempting to do our best by consolidating into one appropriations bill six different appropriations bills that passed with overwhelmingly positive margins out of the Senate Appropriations Committee. There were three bills that received 30 to nothing votes in the Appropriations Committee and three others that were reported out 29 to 1, to give an idea of the kind of support they had. We brought up the Commerce-Justice-Science appropriations bill on October 6. It took us a month to finish that bill because of the delay tactics of the other side. That is the reality of what we face. We have run ourselves into the ground day after day, week after week with amendments relating to things of little or no consequence. I cannot count how many ACORN amendments we voted on. It would be a forest of oak trees if those acorns were planted. But we voted on them regularly, religiously. We made sure we took care of ACORN, but we didn't take care of the people's business because those amendments wasted our time.

These appropriations bills have taken longer and longer because the minority will not agree to reasonable time agreements to consider amendments and finish debate.

Instead, we found ourselves consistently sidetracked by the minority, spending hours on the floor taking the same votes on keeping ACORN from receiving money from different Federal agencies like the Interior Department.

So, here we are. We have 21 days before the end of the calendar year and we need to finish the business of the Congress.

To do so, we engaged Republican members of the Appropriations Committee and worked on reasonable compromises to the differing bills in the House and Senate.

This package of appropriations bills is the result of a truly bicameral and bipartisan effort.

This package represents the priorities of the American people. The conference report invests in students, veterans and law enforcement.

The bill before us makes college education more affordable for students by increasing Pell grants to $5,500.

This will help all students, whether they are going to college for the first time or going back to acquire new skills, get the college education necessary to compete in the global economy.

The conference report also helps local governments fight crime and puts more police on our streets.

We have increased grants for State and local law enforcement by $480 million over last year.

These grant programs were cut by almost $2 billion during the last administration.

This conference report sets the right priorities by increasing funding essential to helping our States and local police departments fight crime.

We also help local law enforcement with hiring and training by including $298 million for the Community Oriented Policing Services or COPS program to put more cops on the beat.

This funding will help hire or retain approximately 1,400 police officers.

The COPS program has helped train nearly 500,000 law enforcement personnel and put over 121,500 additional officers on the beat nationwide.

This conference report also helps keep our promise to our Nation's veterans by increasing funding for the Veterans Affairs Department by $5.3 billion above last year's level.

This funding will increase access to quality health care for our veterans. In particular, the conference report increases discretionary spending at the VA by more than $5 billion to help the VA care for the more than 6.1 million veterans they expect to see in 2010.

As chairman of the subcommittee responsible for Division C of this consolidated appropriations bill, I would like to take the next few minutes to describe the key components of that portion of this bill.

Before doing so, I want to recognize and commend my ranking member, Senator COLLINS, for her helpful counsel, input, and support in crafting the bill. It has been a privilege and pleasure to collaborate with her in addressing the needs of the agencies and programs dependent on funding under our division of this conference agreement. I am proud that we have produced a truly bipartisan product.

This conference agreement allocates budgetary resources totaling $46.3 billion. This consists of $24.2 billion in discretionary spending and $22.1 billion in mandatory spending for financial services and general government accounts. The discretionary funds are $1.6 billion above the fiscal year 2009 enacted level and $40 million less than the President's request.

Our work has provided a valuable opportunity to evaluate the responsibilities, functions, and budgetary needs of the diverse agencies and programs under our jurisdiction. Our challenge has been deliberating carefully to make tough decisions within our conference funding allocation to address many worthy requests.

The bill provides resources for the Department of the Treasury, the Executive Office of the President and White House operations, the Federal judiciary, and the District of Columbia.

In addition, the bill funds over two dozen independent and vital, but often obscure, Federal agencies responsible for a wide array of critical functions in the delivery of public services.

I would like to share some of the highlights of the bill:

My top priority this year was to continue to address the resource needs of two of our Nation's premier regulatory agencies: the Securities and Exchange Commission and the Commodity Futures Trading Commission. These two agencies occupy pivotal positions at the forefront of stimulating and sustaining economic growth and prosperity in our country.

The CFTC received its fiscal 2010 funding as part of the Agriculture appropriations bill, signed into law in September. I am pleased to have played a role in providing that agency with $168.8 million, a 16-percent boost above last year.

For the Securities and Exchange Commission, this bill includes $1,111,000,000, an increase of $85 million above the President's budget request and $151 million more than the fiscal year 2009 enacted level.

The SEC is the investor's advocate. I want to make certain that the SEC has

the necessary resources to effectively fulfill its singular obligation: protecting shareholders.

SEC Chairman Mary Schapiro has charted an aggressive new course to strengthen SEC vigilance by recruiting professional expertise and investing in enhanced technology. The $85 million increase in this bill will support 420 additional investigators, attorneys, and analysts to expand significantly the SEC's enforcement, examination, risk assessment, and market oversight functions.

In addition, the SEC will be able to accelerate investments in several key information technology projects, including installing and launching a new system to track tips and complaints.

The conference bill supports community and small business development at a time when these investments are more crucial than ever. With the economy struggling, economic development must be a top priority.

Treasury's Community Development Financial Institutions Fund program—CDFI—helps finance community development projects throughout the country and supports basic financial services for underserved communities. The bill provides $166.8 million for CDFIs to provide financing for projects such as day care centers, community centers, and affordable housing projects in America's underserved neighborhoods.

Through the Small Business Administration, the bill provides over $824 million to promote the development of America's small businesses. The bill supports $28 billion in new lending to small businesses, providing financing opportunities for small businesses at a time when private sector credit is difficult, if not impossible, to access. The bill also provides $22 million for microloan technical assistance grants and supports $25 million in microlending.

Funding also supports SBA's partners, including Small Business Development Centers, Women's Business Centers, and Veterans Business Outreach Centers. These partners form a foundation of support to help America's small businesses weather the economic downturn and assist newly unemployed Americans seeking advice on starting a small business as a new career path.

As we have done in the past few years, this bill provides a significant funding increase for the Consumer Product Safety Commission. To help keep CPSC on track to meet its new responsibilities under the Consumer Product Safety Improvement Act, the bill provides $118.2 million, an increase of $13 million above last year's level and $11 million above the budget request.

These funds will help expand the import safety initiative, which puts CPSC inspectors at key U.S. ports, and to further investigate suspected problems with imported drywall from China. With these resources, the CPSC can provide the nation with a robust safety program and protect the public against unreasonable risk of injury associated with consumer products.

For the Internal Revenue Service, the bill provides $12.2 billion. Of this, $7 billion is for tax law enforcement, $387 million more than last year, to help advance the administration's initiative to target wealthy individuals and businesses who avoid U.S. taxes by sheltering money in overseas tax havens.

The bill provides nearly $6.4 billion to enable the Federal judiciary to carry out constitutional responsibilities to administer justice and resolve disputes impartially under the rule of law.

Of the $752 million in Federal funding for the District in this bill, the largest portion, $563 million, is designated for the local courts and criminal justice system including public defender services and pretrial and postconviction offender supervision.

In addition, the bill provides a total of $186 million in Federal funds for local District of Columbia activities under the control of the mayor. Of this amount, $110 million is for education-related functions, specifically support for local school improvement and post-secondary tuition assistance.

This $110 million continues our commitment to improving the quality of education for children in the District of Columbia. I convened two hearings this fall to assess the Federal investment in school improvement over the past 5 years. To date, including this bill, Congress has provided $348 million since fiscal year 2004 as special payments to help the District address long-standing deficiencies in its education system.

This conference agreement provides $75.4 million for school improvement in the District in three sectors: $42.2 million for public schools, $20 million for charter schools, and $13.2 million for opportunity scholarships. The bill also includes $35.1 million to continue the District of Columbia resident tuition assistance grant program which permits eligible District residents to attend out-of-state colleges and universities at in-state tuition rates.

Finally, just a few words about earmarks. This is a very transparent appropriations bill shining a light on requests from Senators, House Members, and the Obama administration. Quite frankly, that is the way it should be.

Nothing is buried or disguised. The name of every Member who has asked for anything in the House or Senate bill that has been included in this conference agreement is disclosed in the explanatory statement. Every Member has to stand by every request he or she makes, and it is printed right there for the world to see.

After the document went to print, Senator SCHUMER submitted a letter to the committee conveying his support for several items included in the bill at the request of House members.

I ask unanimous consent to have the text of Senator SCHUMER's letter printed in the RECORD.

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

U.S. SENATE,
Washington, DC, December 7, 2009.

Hon. RICHARD DURBIN,
Chairman, Subcommittee on Financial Services and General Government, Senate Committee on Appropriations, Dirksen Senate Office Building, Washington, DC.

Hon. SUSAN COLLINS,
Ranking Member, Subcommittee on Financial Services and General Government, Senate Committee on Appropriations, Hart Senate Office Building, Washington, DC.

DEAR CHAIRMAN DURBIN AND RANKING MEMBER COLLINS: As your Subcommittee works toward a conference with the House of Representatives on the Fiscal Year 2010 Financial Services and General Government Appropriations bill, I respectfully request your support for several projects that are important to the state of New York, as well as to our nation.

I urge the Senate Conferees to fully fund my priority project included in the FY10 Senate version of the Financial Services Appropriations bill:

Support the Senate Appropriations Committee (SAC) addition of $117,500 for the City of Buffalo for the Buffalo Clean Energy Incubator, in the Small Business Administration account;

Support the SAC addition of $117,500 for the Community Service Society of New York for a financial education project, in the Small Business Administration account;

Support the SAC addition of $117,500 for the Greater Syracuse Chamber of Commerce for the Space Alliance Technology Outreach Program, in the Small Business Administration account.

In addition to my Senate priorities, I also offer my support for the following projects included in the House version of the bill:

Support the House Appropriations Committee (HAC) addition of $17,500,000 for National Archives and Records Administration, Washington, D.C., for FDR Presidential Library, New York, in the National Archives and Records Administration account;

Support the HAC addition of $150,000 for Agudath Israel of America, New York, NY, for Mentoring and training services, in the Salaries and Expense account;

Support the HAC addition of $250,000 for the Buffalo Niagara International Trade Foundation, Buffalo, NY, to support small businesses, in the Salaries and Expenses account;

Support the HAC addition of $150,000 for the Center for Economic Growth, Albany, for Watervliet Innovation Center, in the Salaries and Expenses account;

Support the HAC addition of $150,000 for the Consortium for Worker Education, New York, NY, for Financial training and guidance programs, in the Salaries and Expenses account;

Support the HAC addition of $151,000 for Girl Scouts of the USA, New York, NY, for a national program to improve financial literacy, in the Salaries and Expenses account;

Support the HAC addition of $200,000 for Greater Syracuse Chamber of Commerce, Syracuse, NY, for Clean Tech Startup Camp, in the Salaries and Expenses account;

Support the HAC addition of $350,000 for Hudson Valley Agribusiness Development Corporation, Hudson, NY, for Hudson Valley Food Processing Incubator Facility, in the Salaries and Expenses account;

Support the HAC addition of $75,000 for Hunter College, New York, NY, for the Roosevelt House Institute Public Policy Institute, Financial Literacy Project, in the Salaries and Expenses account;

Support the HAC addition of $150,000 for Metropolitan Council on Jewish Poverty, New York, NY, for Employment and training programs, in the Salaries and Expenses account;

Support the HAC addition of $100,000 for New York College of Environmental Science & Forestry, Syracuse, NY, for the New York Forest Community Economic Assistance Program, in the Salaries and Expenses account;

Support the HAC addition of $125,000 for Pace University Lienhard School of Nursing, White Plains, NY, for nursing workforce education and training initiative, in the Salaries and Expenses account;

Support the HAC addition of $85,000 for Pratt Institute, Brooklyn, NY, for Green Community Career & Business Training Center, in the Salaries and Expenses account;

Support the HAC addition of $150,000 for SUNY Fredonia, Fredonia, NY, for Small business incubator, in the Salaries and Expenses account;

Support the HAC addition of $100,000 for YMCA of Long Island, Inc., Holtsville, NY, for Diversity Training Program at the Brookhaven-Roe YMCA, in the Salaries and Expenses account.

I certify that to the extent of my knowledge neither I nor my immediate family has a pecuniary interest, consistent with the requirements of Paragraph 9 of Rule XLIV of the Standing Rules of the Senate, in any congressional directed spending item that I requested as reported by the Committee on Appropriations.

I thank you for your consideration of these important requests.

Sincerely,

SENATOR CHARLES E. SCHUMER.

The PRESIDING OFFICER. The majority leader.

CLOTURE MOTION

Mr. REID. Mr. President, we are here at 7 o'clock. My friend—I want to make sure the RECORD reflects that he is my friend—the Republican leader, we scuffle and argue out here, but we have done a lot of things together over the years. But I do have a direct quote from my friend just this afternoon:

> We have been anxious to have health care votes since Tuesday and we have had the Crapo amendment pending since Tuesday. We would like to vote on amendments. All we are asking is an opportunity to offer amendments and get votes.

That is what we have been trying to do now for the last several hours. First of all, I have a cloture motion at the desk with respect to the conference report to accompany H.R. 3288.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the conference report to accompany H.R. 3288, the Transportation, HUD, Related Agencies Appropriations Act for Fiscal Year 2010.

Daniel K. Inouye, Al Franken, Jon Tester, Paul G. Kirk, Jr., Roland W. Burris, Edward E. Kaufman, Jack Reed, Daniel K. Akaka, Mark Begich, Patty Murray, Jeff Bingaman, Robert P. Casey, Jr., Sherrod Brown, Thomas R. Carper, Byron L. Dorgan, Richard J. Durbin, Harry Reid.

Mr. REID. Mr. President, I ask unanimous consent that the mandatory quorum be waived.

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

UNANIMOUS CONSENT REQUEST—H.R. 3590

Mr. REID. Mr. President, I now ask unanimous consent that the Senate resume consideration of H.R. 3590, the health care bill, for the purposes of considering the pending Crapo motion to commit and the Dorgan amendment No. 2739, as modified; that Senator BAUCUS be recognized to call up his side-by-side amendment to the Crapo motion; that once that amendment has been reported by number, Senator LAUTENBERG be recognized to call up his side-by-side amendment to the Dorgan amendment, as modified; that prior to each of the votes specified in this agreement, there be 5 minutes of debate equally divided and controlled in the usual form; that upon the use or yielding back of the time, the Senate proceed to vote in relation to the Lautenberg amendment; that upon disposition of the Lautenberg amendment, the Senate then proceed to vote in relation to the Dorgan amendment; that upon disposition of that amendment, the Senate proceed to vote in relation to the Baucus amendment; that upon disposition of that amendment, the Senate proceed to vote in relation to the Crapo motion to commit; that no other amendments be in order during the pendency of this agreement; that the above-referenced amendments and motion to commit be subject to an affirmative 60-vote threshold and that if they achieve that threshold, then they be agreed to and the motion to reconsider be laid upon the table; that if they do not achieve that threshold, then they be withdrawn.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. As I stated earlier today, and as the majority leader has indicated, we have waited since Tuesday to vote on additional health care amendments, including the pending Crapo motion to commit on taxes. Finally, tonight the other side gave us language on their alternative to Senator CRAPO's motion.

Senator CRAPO's motion would ensure that the bill does not raise taxes on the middle class. I understand that their alternative is sense-of-the-Senate language on that subject. This consent request now has us voting on two drug reimportation amendments from the other side—not one but two on the Democratic side—one of which we just received less than an hour ago and is 100 pages long.

We are prepared to return to the health care bill and proceed to the two tax-related votes tonight. After those votes, I would suggest we continue to work on the bill and other amendments. I assume there could be votes on the drug reimportation issue and a whole host of other amendments we have all been anxious to offer at a later time. But at this stage, regretfully, I object and propound the following alternative.

Is my objection registered?

The PRESIDING OFFICER. Objection is heard.

Mr. MCCONNELL. I would say to my friend, the majority leader, could we just get in the queue the Crapo amendment and the, I believe, Baucus side by side to the Crapo amendment? I ask unanimous consent that we do that, which would give us a way to go forward on two measures that both sides seem to want to vote on.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Just this afternoon, my friend, the Republican leader, said—and I quote—''I think it is pretty hard to argue with a straight face that we're''—''we'' meaning Republicans—''not trying to proceed to amend and have votes on this bill. That's what we desire to do.''

Mr. President, it is obvious the Republicans have said privately to their friends and publicly here and in the media that this is a bill they want to kill. To think they are interested in doing something that is positive about this stretches the imagination.

Also, let me just say this. I did not come to this body yesterday. I am not the expert with procedures in the Senate, but I am pretty good. I want everyone to understand this is a ploy procedurally to stop us from completing this bill. We are not going to have a bunch of amendments stacked up. Amendments have been offered. We are agreeing to vote on the amendments. We know the drug importation is a difficult vote for the Republicans; it is a difficult vote for the Democrats. But that is what we do around here.

Every amendment we have had so far has been 60-vote margins. This should not be any different. So I want the RECORD to reflect that we are ready to vote. He keeps talking about ''since Tuesday.'' There have been quite a few things going on around here since Tuesday. It is not as if we have been sitting around staring in space. There has been good debate on the Senate floor. It is just that we have amendments that would—if we move off the motion they have filed, it creates a procedural issue that we would have difficulty getting out of. That is why they are wanting to do that. We have to clear the deck, continue offering amendments, as we have. I think that is the right way to do it.

So, Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

The Republican leader.

Mr. MCCONNELL. Mr. President, could I just say, at the risk of being redundant—and I do not want to get into

a spirited debate with my friend and colleague over this—the facts are we were just handed a 100-page Lautenberg amendment about an hour ago. I have 39 Members here, all interested in that issue. It is simply impossible for me to clear voting on an amendment of 100 pages in duration that I just got an hour ago.

The reason I had suggested—and I was hopeful that maybe it would be a good way forward—we vote on the Crapo amendment, which everybody understands has been out there since Tuesday, and a sense-of-the-Senate resolution that is fairly brief, I assume—a very brief sense of the Senate that Senator BAUCUS was going to offer—is because both sides fully understand those two measures. They are not 100 pages long and enormously complicated. We did not just receive them.

So I do not want to get into an extensive back and forth with the majority leader, but I would say to him through the Chair, sincerely, it strikes me a good way to just get started would be to vote on these two issues, the Crapo motion and the Baucus amendment that both sides fully understand.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, this is no sucker punch the Democrats have just leveled to the Republicans. This amendment was previously offered by Senator COCHRAN, a Republican, that Senator LAUTENBERG is offering. This is something people have known about for a long time. So I understand people may have forgotten what was in that. They can have the evening to look it over. But I will renew my request tomorrow. We are ready to legislate.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. Mr. President, I guess I will have to prolong it just a little bit further.

I just learned something from the majority leader, that in fact this is an amendment that has been around before. We just learned that from his comments, having just received it a short time ago. Nevertheless, we will continue to talk and see if we cannot move forward and make progress and give both sides votes they are clearly interested in having.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I appreciate the attitude of the Republican leader. I think it is fair to have a chance to look at that amendment. We will be here in the morning and try to work through this.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, what is the pending business before the Senate?

The PRESIDING OFFICER. The omnibus conference report.

Mr. MENENDEZ. Thank you, Mr. President.

Mr. President, I rise to speak about the omnibus conference bill before the Senate and specifically about provisions on Cuba that have not passed the Senate and have not been subjected to debate by this body. These provisions would undo current law where the Castro regime would have to pay in advance of shipment for goods being sold to them because of their terrible credit history.

Yes, Cuba's credit history is horrible. The Paris Club of creditor nations recently announced that Cuba has failed to pay almost $30 billion in debt. Among poor nations that is the worst credit record in the world.

So I ask: If the Cuban Government has put off paying those to whom it already owes $30 billion, why does anyone think it would meet new financial obligations to American farmers?

Considering the serious economic crisis we are facing right now, we need to focus on solutions for hard-working Americans, not subsidies for a brutal dictatorship. We should evaluate how to encourage the regime to allow a legitimate opening—not in terms of cell phones and hotel rooms that Cubans cannot afford but in terms of the right to organize, the right to think and speak what they believe.

However, what we are doing with this omnibus bill is far from that evaluation, and the process by which these changes have been forced upon this body is so deeply offensive to me and so deeply undemocratic that I have no intention—no intention—of continuing to vote for Omnibus appropriations bills if they are going to jam foreign policy changes down throats of Members in what some consider ''must-pass'' bills.

I am putting my colleagues on notice: You may have the wherewithal to do that because you have a committee perch or an opportunity to stick something in that has not been debated on the floor of the Senate in what you think is a must-pass bill, but do not expect me to cast critical votes to pass that bill.

An example of the danger of what we are doing by changing the definition that is now being changed in this omnibus bill of what we call ''cash in advance'' is exhibited by a Europapress report. I want to quote from that press report: ''During a trade fair this month in Havana, Germany's Ambassador to Cuba, Claude Robert Ellner, told German businessmen that Cuba's debt to the German government had been forgiven''—forgiven—''in the hopes that Cuba will meet its debt obligations to them''—meaning to the businessmen.

In other words, German taxpayers will now be responsible for bailing out its private sector and, by implication, the Castro regime.

Thanks to the U.S. policy we have had up to now, of requiring the Castro regime to pay ''cash in advance'' for its purchases of agricultural products, U.S. taxpayers could rest assured that the same would not happen to them—that we would not have to forgive any debt or obligations in order to make sure private businesspeople got paid by the regime because, otherwise, they would be left defaulted.

The Castro regime has mastered the art of making some European Governments acquiesce to its every whim, even if it means a free pass for its daunting repression.

So how do they do it? It is rather simple. They give European countries a choice: either you do what we say or we will freeze your nationals' bank accounts and default on any debts. To me, that is also known as blackmail.

Let's take Spain, for example. Recently, European news services reported that Spain has begun a diplomatic offensive to convince the Castro regime to unblock nearly 266 million euros—or the equivalent of about 400 million United States dollars—in funds that have been frozen by the Castro regime of over 300 Spanish companies in Cuba. These are Spanish companies doing business in Cuba and now cannot get access to their money.

So what does the Spanish Government do? Not coincidentally, the Spanish Government announced that upon assuming the Presidency of the European Union in 2010, it would enter into a new bilateral agreement with the Castro regime that would replace the current European Union policy which contains diplomatic sanctions for human rights violations.

The Castro regime had made it clear to Spain that the current European Union policy was an ''insurmountable obstacle'' to normal relations and, I might add, for Spanish nationals and companies to get their money back. Therefore, the Spanish Government immediately responded to what I consider to be blackmail.

On a recent visit to Cuba, Spain's Foreign Minister, Miguel Angle Moratinos, met for 3 hours with Raul Castro. He did not get one concession—not one—on human rights. But he did get $300 million that Cuba owed to Spanish companies that do business inside of Cuba.

Is that what the United States of America intends to do?

So the lesson for dictators is, go ahead and freeze the bank accounts of other countries' companies and create debt you do not intend to pay for and you get a free pass for repression.

Look at another article. A recent Reuters article highlights that Cuba continues to block access to foreign business bank accounts. Let me quote from that article:

> Many foreign suppliers and investors in Cuba are still unable to repatriate hundreds of millions of dollars from local accounts almost a year after Cuban authorities blocked them because of the financial crisis, foreign diplomats and businessmen said.

It goes on to say in the article:

> The businessmen, who asked not to be identified—

Because they are fearful if they are—

> said they were increasingly frustrated because the Communist authorities refused to offer explanations or solutions for the situation, which stems from a cash crunch in the

Cuban economy triggered by the global downturn and heavy hurricane damage last year.

This is a quote from one of those people. He says:

I have repeatedly e-mailed, visited the offices and sent my representative to the offices of a company I did business with for years and which owes me money, and they simply refuse to talk to me.

That is what a Canadian businessman told Reuters.

The article goes on:

Delegations from foreign banks and investor funds holding commercial paper from Cuba's State banks have repeatedly traveled to Cuba this year seeking answers from the Central Bank or other authorities—without success.

Representatives of some companies with investment or joint ventures on the island say they were bracing for the possibility of not being able to repatriate year-end dividends paid to their accounts in Cuba.

Now, let's remember that some 90 percent of the country's economic activity is in the regime's hands, in the state's hands.

Foreign economic attachés and commercial representatives in Cuba said most of their nationals doing business with the Caribbean island still face payment problems.

That is all from that article. These are all those who are doing business with Cuba now finding themselves and their money trapped.

Last week, the Russian Federation's Audit Chamber revealed that the Cuban regime failed on three occasions to pay installments on the equivalent of $355 million in a credit deal it signed with Russia in September of 2006. That is just the latest episode in a saga that in 2009 alone includes, first, reports by Mexico's La Jornada and Spain's El Pais newspapers that hundreds of foreign companies that transact business with the Cuban regime's authorities have had their accounts frozen—frozen—since January of 2009 by the regime-owned bank that is solely empowered to conduct commercial banking operations in that country.

Second, a June 9, 2009, Reuters article said:

Cuba has rolled over 200 million Euros in bond issues that were due in May, as the country's central bank asked for another year to repay foreign holders of the debt, financial sources in London and Havana said this week.

Those are direct quotes from those articles.

As a reminder, in Castro's Cuba, you can only do business with the regime because private business activity is strictly restricted.

So the real reason so many whose work is often subsidized by business interests advocate Cuba policy changes is about money and commerce, not about freedom and democracy. It makes me wonder why those who spend hours and hours in Havana listening to Castro's soliloquies cannot find minutes—minutes—for human rights and democracy activists. It makes me wonder why those who go and enjoy the Sun of Cuba will not shine the light of freedom on its jails full of political prisoners. They advocate for labor rights in the United States, but they are willing to accept forced labor inside of Cuba. They talk about democracy in Burma, but they are willing to sip the rum with Cuba's dictators.

Which takes me to a place in Cuba called Placetas. Placetas is a city in the Villa Clara Province in the center of Cuba, in the heart of the island, in the center of Cuba. In other words, it is not a beachside resort frequented by Canadian and European tourists.

Placetas is also the home of this couple. It is the home of Cuban political prisoner and prodemocracy leader Jorge Luis Garcia Perez Antunez, generally known as Antunez. On March 15 of 1990, a then-25-year-old Antunez stood at the center square of Placetas listening to the government's official radio transmission calling for the Fourth Congress of the Communist Party. He spontaneously began to shout: ''What we want and what we need are reforms like the ones performed in Eastern Europe.'' Immediately, he was beaten by state security agents, charged with ''oral enemy propaganda,'' and imprisoned. That would begin a 17-year prison term, which is about half of his current life that he spent in prison. His crime? Saying: We need the types of changes that took place in Eastern Europe. For that, 17 years in prison. He was not released until 2007. He is now 45 years old, hopefully with an entire life ahead of him.

The Castro regime would love for Mr. Antunez and his wife, who is also a prodemocracy activist—this says in Spanish, ''we are all the resistance'' and ''long live human rights.'' They would love for him to leave the island permanently, but he refuses to do so. He has decided to stay in Cuba and demand that the human and civil rights of the Cuban people be respected. For this, he has been rearrested over 30 times since 2007.

Last week, at that same center in that small town of Placetas where he had been originally arrested simply for saying that: What we need is a change as we saw in Eastern Europe, Antunez and other local prodemocracy leaders gathered to honor Cuba's current political prisoners, people who simply, through peaceful means, try to create changes for democracy and human rights inside of their country and get arrested and languish in jail.

Antunez and his colleagues were not ''educated'' on the importance of human rights and civil disobedience by foreign tourists, as some of my colleagues suggest would happen—that we need to send foreign tourists to educate the Cubans about human rights and civil disobedience. He and all of those who are languishing in Castro's jails understand about human rights and civil disobedience in a way to try to capture your rights. Unwittingly, though, foreign tourists have financed their repression. They give money to the regime that ultimately gives them the state security forces that throw people such as Antunez in jail.

Let me read an open letter that just came out by Mr. Antunez that was sent to Cuba's dictator Raul Castro. I am going to quote from an English translation.

It says:

Mr. Raul Castro—

This is Mr. Antunez speaking now—

My name is Jorge Luis Garcia Perez Antunez—a former political prisoner—and I am writing to you again not because I pretend to make you aware of something that, far from alien, is commonplace in Cuba due to the nature and politics of your government. For several months now my spouse Yris Tamara Perez Aguilera and I find ourselves under forced house arrest by your political police. The week before the Juanes concert—

That is the concert of the famous Colombian singer Juanes—

a high ranking State security official upon arresting me informed me that there had been an order for my arrest throughout the island of Cuba, wherever I might be found. He emphasized that they were going to be watching every step I take. Since that date I have lost count of how many times I have been arrested, the majority of times with violence.

Mr. Dictator—allow me a few questions that may help you clarify some doubts amongst those compatriots of mine who are hopeful that your government would diminish repression or that even Democratic openings could be made.

He poses this question:

With what right do the authorities, without a prior crime being committed, detain and impede the free movement of their citizens in violation of a universally recognized right? What feelings could move a man like Captain Idel Gonzalez Morfi to beat my wife, a defenseless woman, so brutally, causing lasting effects to her bones for the sole act of arriving at a radio station to denounce with evidence the torture that her brother received in a Cuban prison. Or is it that for you there are only five families that exist in our country that have the right to protest and demand justice for their jailed relatives? Should you not be ashamed that your corpulent police officers remain stationed for days at the corner of my home to impede us from leaving our house and monitoring our movements in our own city?

Where is the professionalism and ethics of your subordinates that with their ridiculous operations provoke the mockery of the populace towards these persons on almost a daily basis? How do you feel when you encourage or allow these persons who call themselves men to beat and drag women through the streets such as: Damaris Moya Portieles, Marta Diaz, Ana Alfonso Arteaga, Sara Marta Fonseca, Yris Perez, and most recently—

The well-known blogger, Yoani Sanchez. I am adding for the record ''the well-known blogger.'' He doesn't say that, but she is a well-known blogger, internationally known, recently beaten simply as she was trying to go to a place of civil disobedience.

How can you and your subordinates sleep calmly after deliberately and maliciously physically knocking down on more than one occasion Idania Yanez Contreras who is several months pregnant? How can you and your government speak about the battle of ideas

when you are constantly repressing ideas through beatings, arrests, and years of incarceration?

Maybe your followers cannot find or even attempt to find a response. However, I find myself in the long list of persons that are not afraid to respond.

You act this way because you are a cruel man, and insensible to the pain and suffering of others. You act this way because you are faithful to your anti Democratic and dictatorial vocation, because you are convinced that dictatorships like the one you preside over can only be maintained through terror and torture, and because the most minimal opening can lead to the loss of the one thing that you are interested in—which is maintaining yourself in power.

Lastly, returning to my case in particular, I will respond without even asking you beforehand the concrete motives of your continued repression against my person. Your government and your servants in the repressive corps cannot forgive my two biggest and only ''crimes.'' First, that despite almost two decades of torture and cruel and inhuman punishment during my unjust and severe sanction, you could not break my dignity and my position as a political prisoner. And second, because even though I am accosted and brutalized and above all risk returning to prison, I have taken the decision not to leave my country in which I will continue struggling for a change that I believe is both necessary and inevitable.

The letter is signed: From Placetas, Jorge Luis Garcia Perez Antunez, December 2009.

This is the voice of those who languish under Castro's brutal dictatorship. As you can see, Mr. Antunez is an Afro-Cuban, not part of the White elite of the regime's dictatorship; not what the regime tells the world, that Cubans who are all White seek to oppose the dictatorship. Most of the movement for democracy inside of Cuba are Afro-Cubans. Inside of Cuba, they are subjected to a citizenship status that is less than any human being should be subjected to.

Antunez's voice rings in my head. It tugs at my conscience.

His words:

Despite almost two decades of torture and cruel and inhuman punishment during my unjust and severe sanction, you could not break my dignity and my position as a political prisoner, because even though I am accosted and brutalized and above all risk returning to prison, I have taken the decision not to leave my country in which I will continue struggling for a change I believe is both necessary and inevitable.

Antunez is right. Change in Cuba is inevitable, but the United States needs to be a catalyst of that change. It does not need to be a sustainer of that dictatorship. It does not need to create an infusion of money that only goes to a regime that ultimately uses it not to put more food on the plates of Cuban families but to arrest and brutalize people such as Mr. Antunez.

These are the human rights activists on whom some would turn their backs for the sake of doing business. I guess the only thing they can see is the color of money. Well, not me, not now, and not ever.

Thank you, Mr. President. With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I don't rise to add to what the Senator from New Jersey said. I just wish to take this opportunity to tell him I agree with him, and I appreciate his leadership on this issue over several years—even the years before he came to the Senate.

Often, I am asked in my State, because we can export so much agricultural stuff, if I would vote to open trade with Cuba. I said I am willing to open trade for Cuba when they give political freedom and economic freedom to the people of that country because this dictator has run Cuba into the most impoverished country in the world. Before he took over, they had a very viable middle class and they were a prosperous country.

I stand ready to help the Senator on what he is trying to do in that area.

Mr. MENENDEZ. If the Senator will yield, I thank the distinguished Senator from Iowa for his comments and for the position he has taken over a long period of time. It may not be the easiest, but I believe it is the one that is morally correct. Most important, on that day—which I believe is sooner rather than later—in which Cubans are free, they will remember who stood with them in the midst of this. That will make all the difference in the world. I thank the Senator.

Mr. GRASSLEY. Mr. President, I come to the floor at this point to give some breadth to a statement that was made on the floor earlier today. It was made by my friend, Senator BAUCUS. I don't take offense to what he said because I sensed a great deal of frustration in his statement. I will read what he said so you know what I am reacting to. The reason I don't take offense to what he said is because he and I have worked so closely together over 10 years, with one or the other of us being chairman of the Finance Committee, that we have such an understanding of each other.

Just prior to the remarks I am going to read, he had spoken positively about Senator ENZI and me. So I want my colleagues to know this statement is not made out of anger that I am going to give a rebuttal to.

Well, we kept working bipartisan—working together, for days and days, hours and hours, and then, fortunately, Mr. President, it got to the point where I'm just calling it as I see it. I can't—I—one of my feelings is I'm too honest about things. And it's—the Republicans started to walk away. They pulled away from the table. They had to leave.

I ask you why? Why did that happen? And the answer is, to be totally fair and above board, is—and above board, is because their leadership asked them to. Their leadership asked them to become disengaged from the process. I know that to be a fact. Why did their leadership ask Republicans to leave and become disengaged from the process? To be totally candid, they wanted to score political points by just attacking this bill. They were not here to help—help be constructive, to find bipartisan solutions. They were for a while, then when the rubber started to meet the road and it came time to try to make some decisions, they left and began to attack—and began to attack.

I wish to take a few minutes to respond to these remarks that I read. It was asserted, through these remarks on the floor, that some Republicans in the so-called Gang of 6 were directed by the Senate Republican leadership to cease participating in bipartisan talks. The Gang of 6 referred to the six bipartisan members of the Senate Finance Committee. On the Democratic side, the members were my friends, three chairmen, including Senator BAUCUS, Budget Committee chairman; Senator CONRAD; and Energy Committee chairman, Senator BINGAMAN. All are senior members of the Democratic Caucus. On the Republican side, the three members included Senator SNOWE, ranking member of the Small Business Committee; Senator ENZI, ranking member of the Health, Education, Labor, and Pensions Committee; and this Senator. Senators SNOWE and ENZI are senior Members of the Republican caucus.

Chairman BAUCUS convened this working group with a singular goal of a bipartisan health care reform bill. We met for several weeks up in the Montana Room of Chairman BAUCUS's office. I would agree with the way participating Members have described these discussions. They were well informed, thoughtful, provocative, challenging, and frustrating all at the same time. But I would say that in the months we negotiated, there was never once that anyone walked away from the table. There was never once that there were any harsh words.

While we were engaged in those discussions, there was constant pressure from folks outside the room for us to reach a quick deal. That pressure came from the White House, it came from the Democratic leadership, it came from advocacy groups outside, and it came from many media folks covering the day-by-day meetings. To be fair, the Senate Republican leadership was very concerned about some of the directions the policy discussions were taking in the Gang of 6. That concern grew, particularly after the very partisan HELP Committee markup occurred. Senator HATCH left the original Gang of 7 because of the character and result of the HELP Committee markup.

Most important, the Senate Republican leadership was concerned that a bipartisan Finance Committee bill would be co-opted into a partisan floor bill, when the Democratic leadership merged the bills. Senators SNOWE, ENZI, and I anticipated that concern.

To be fair to Senator BAUCUS, as he was negotiating with us, he tried to convince us that we would be very much a part of those merging of the bills. He offered that in good faith. I believe him. I even believe him today saying that. But seeing how neither the HELP Committee nor the Finance Committee was as involved as they should have been in what Senator REID

put together in this 2,074-page bill, I wonder whether Senator BAUCUS could have, if we had a bipartisan agreement, actually carried out that guarantee.

From the get-go, we Republican members of the Gang of 6, to make sure we were a part of the process that I described, as Senator BAUCUS told us we would be, asked for assurances from the White House and from the Senate Democratic leadership on the next step in the legislative process, if we, in fact, did arrive at a bipartisan agreement.

I also found that many in the broader group of Republicans, who provided the bipartisan glue for the CHIP bill of 2008, had similar concerns. All Republicans had process concerns, such as where would it go once it left the Senate Finance Committee.

We wanted assurances, and here is what we wanted. The assurances requested boiled down to a good-faith promise that the bipartisan Finance Committee health care bill would not morph into a partisan health care reform bill when Majority Leader REID merged the two committee bills. We wanted to make sure the bipartisan character of a bipartisan Finance Committee bill was going to be retained through these next steps. To do otherwise would be akin to getting on a bus and not knowing where the bus was going or how much the bus ticket would cost. Assurances were also requested with respect to a conference between the House and Senate. The assurances were similar to assurances requested by Senator REID and made by the then-majority Republican leadership during the period of 2005 and 2006. The Democratic minority leader, at that time, made these assurances a condition to letting major regular order Finance Committee bills even go to conference.

As an example, take a look at the CONGRESSIONAL RECORD, and you will see the assurances made by then-Majority Leader Frist to then-Minority Leader REID. These requests were made repeatedly to the Democratic leadership, publicly and privately, about how the postcommittee action of the bipartisan group would be handled in the merger with the HELP Committee bill. It was a focus of a July 8 lunchtime, face-to-face meeting at the majority leader's office, with Senators REID, BAUCUS, CONRAD, BINGAMAN, SNOWE, ENZI, and myself. The bottom-line response from Senator REID at that meeting was he needed 60 votes.

I guess, the implication was, despite the fact that the Democratic caucus contained 60 members then and now, Senator REID didn't think it was possible to secure the votes of all members of his caucus. A restatement of the reality of the Senate rules was not the assurances the three Republican Senators—this one included—sought from Senator REID.

Senator REID, himself, recognized the validity of this request in an August 8 Washington Post article. I ask unanimous consent to have that article printed in the RECORD.

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

[From the Washington Post, Aug. 3, 2009]

DEMOCRATS FIND RALLYING POINTS ON HEALTH REFORM, BUT SPLINTERS REMAIN

(By Shailagh Murray and Paul Kane)

Democrats leave town for the August recess with frayed nerves and fragile agreements on health-care reform, and a new bogeyman to fire up their constituents: the insurance industry.

With the House already gone and the Senate set to clear out by Friday, the terms of the recess battle are becoming clear. Republicans will assail the government coverage plan that Democrats and President Obama are advocating as a recklessly expensive federal takeover of health care. And Democrats will counter that GOP opposition represents a de facto endorsement of insurance industry abuses.

''We know what we're up against,'' House Speaker Nancy Pelosi (Calif.) told reporters on Friday. ''Carpet-bombing, slash and burn, shock and awe—anything you want to say to describe what the insurance companies will do to hold on to their special advantage.''

Although Pelosi won a significant victory last week when the Energy and Commerce Committee approved the House bill, setting up a floor debate after Labor Day, conservative Democrats were able to demand that negotiators weaken the government-plan provision. The uprising, which lasted for several days, suggested that the public option is growing increasingly vulnerable even as a consensus forms around other reform policies.

Republican leaders have pledged to use town halls, ads and other forums to intensify their assault on the Democratic-led reform effort. ''I think it's safe to say that, over the August recess, as more Americans learn more about [Democrats'] plan, they're likely to have a very, very hot summer,'' House Minority Leader John A. Boehner (R–Ohio) said.

In the Senate, a bipartisan coalition of Finance Committee lawmakers is backing a member-run cooperative model as an alternative to the public option. But Republicans are beginning to push back against that cooperative approach, too.

The latest critic is Sen. John McCain (R–Ariz.), who on Sunday compared insurance co-ops to Fannie Mae and Freddie Mac, the government-backed mortgage giants that played prominent roles in the housing crisis. ''I have not seen a public option that, in my view, meets the test of what would really not eventually lead to a government takeover,'' McCain said on CNN's ''State of the Union.''

Pelosi and other Democrats have countered that Republicans are seeking to protect a health insurance industry that is their business ally, not so much from a government insurance option, but from the broad industry reforms that enjoy public support, including the elimination of coverage caps and the practice of denying coverage to those with pre-existing conditions. The White House also wants to steer the debate toward insurance reform, as it is easier to digest than long-term cost control, which is another chief objective.

''How you regulate the insurance industry is as important to health-care reform as controlling costs,'' said White House Chief of Staff Rahm Emanuel. The public plan, he said, is one of an array of measures intended to change industry behavior.

As the rhetoric against the industry heated up, the leading insurance trade group issued a statement Thursday calling for lawmakers to cool down their criticisms and redouble efforts toward ''bipartisan health-care reform.'' Robert Zirkelbach, spokesman for America's Health Insurance Plans, defended his industry, saying it had already proposed many of the changes that Congress is seeking, including those involving pre-existing conditions and ratings based on health status and gender.

Despite the sparring, House and Senate Democrats and three GOP Senate negotiators have reached broad consensus on the outlines of reform. Lawmakers generally agree that individuals must be required to buy health insurance, that Medicaid should be significantly expanded, and that tax increases, in some form, will be required. The final bill also could bring about some of the most significant changes to Medicare since the program was created in 1965.

But the rebellion from fiscal conservatives on the Energy and Commerce Committee last week served as a political wake-up call for Democratic leaders. With enough votes on the panel and on the floor to sink reform legislation, the Blue Dog Coalition forced Pelosi and Emanuel into concessions that made the government plan similar to private health insurance, sparking a new fight with House liberals.

Sensing that the Blue Dogs had dug in for a prolonged fight, Pelosi and Emanuel gave in to most demands in order to get the legislation moving again. They essentially decided that it was better to pick a fight with their liberal flank, where Pelosi remains popular and where loyalty to Obama is strongest, particularly in the Congressional Black Caucus.

Despite threats from almost 60 progressive House Democrats—who outnumber the Blue Dogs—Pelosi defended the compromise, saying it was similar to one backed by Sen. Edward M. Kennedy (D–Mass.). Pelosi predicted that the liberal wing would fall in line because the legislation is so important to them.

''Are you asking me, 'Are the progressives going to take down universal, quality, affordable health care for all Americans?' I don't think so,'' Pelosi told reporters Friday, breaking into laughter at the question.

Just as troublesome as the internal House divisions is the burgeoning distrust among House Democrats, their Senate counterparts and the White House.

Pelosi acknowledged that ''there are concerns'' in her caucus that the White House, namely their former colleague Emanuel, takes House Democrats for granted. House lawmakers are being encouraged to pass the most liberal bill possible, she said, while the White House works on a bipartisan compromise with a select group of senators.

''It's no secret,'' Pelosi said, ''that members sometimes think: 'Why do I always read in the paper that they're checking with the Finance Committee all the time? What does that mean, that they just want to know what's happened with the Finance Committee? What about the [Senate health] committee? What about our committees over here?' ''

The six Senate Finance Committee negotiators have burrowed in for another six weeks of talks, having set a Sept. 15 deadline for producing a bill. The group includes an array of small-state senators with little national prominence who have proven surprisingly resistant to pressure from their party leaders and the White House.

Although the House bill and the Senate Health Committee version have attracted no Republican support, the Senate Finance Committee coalition includes Sens. Mike Enzi (Wyo.) and Charles Grassley (Iowa), both Republicans, along with moderate GOP Sen. Olympia Snowe (Maine). And the lead Democratic negotiator, Finance Committee

Chairman Max Baucus (Mont.), is a moderate who has broken with his party on numerous bills co-authored with Grassley.

The closer these negotiators move to striking a deal, the more fraught the discussions become by issues of trust and political will. Among Republicans, the pressure is especially acute. All three GOP senators fear they will be sidelined once the bill is approved at the committee level, with their names invoked to demonstrate bipartisanship even as they're left with no say over the final product as it is meshed with the Senate health panel's version and then ultimately with the House bill.

For Republicans, a prime concern is that Senate Majority Leader Harry Reid (Nev.) will abandon the Finance Committee bill and force legislation to the Senate floor using budget rules that would protect against a Republican filibuster. Even advocates concede that the option is highly risky and that it would vastly limit the policy scope of the bill. For instance, Senate budget experts say most insurance reforms would have to be sidelined.

Treasury Secretary Timothy F. Geithner said Sunday that the administration would consider all options. ''Ideally, you want to do this with as broad a base of consensus as possible,'' he said in an interview on ABC's ''This Week.'' ''But people on the Hill are going to have to make that choice: Do they want to help shape this and be part of it, or do they want this country, the United States of America, to go another several decades [without reform]?''

Reid said he already provided the Republicans with some assurances, and added, ''I'll do more if necessary.'' He said of GOP concerns, ''I don't blame them.'' And he added that, considering the political realities of the Senate, with its large number of moderate Democrats, health-care reform would have to gain significant bipartisan support to cross the finish line.

''I sure hope we can get a bipartisan bill; it makes it easier for me to go home,'' moderate Sen. Mary Landrieu (D–La.) told the Democratic caucus last week, according to Reid.

''We all feel that way,'' Reid added.

Mr. GRASSLEY. Mr. President, I will quote, in part, from the article:

The closer these negotiators move to striking a deal, the more fraught the discussions become by issues of trust and political will. Among Republicans, the pressure is especially acute. All three GOP senators fear they will be sidelined once the bill is approved at the committee level, with their names invoked to demonstrate bipartisanship even as they're left with no say over the final product as it is meshed with the Senate health panel's version and then ultimately with the House bill.

Republicans were also worried that the bipartisan product could be lifted into a partisan reconciliation bill. I quote further from that same Post article:

Reid said he already provided the Republicans with some assurances, and added, ''I'll do more if necessary.''

Continuing to quote from the Post article:

He said of GOP concerns, ''I don't blame them.'' And he added that, considering the political realities of the Senate, with its large number of moderate Democrats, health-care reform would have to gain significant bipartisan support to cross the finish line.

President Obama and the Senate Democratic leadership set a deadline of September 15 for the bipartisan Gang of 6 to produce a proposal. If the proposal were not available by then, the President and Senate Democratic leadership made it clear the plug would be pulled on further bipartisan talks.

I point that out because that is very significant. A powerful member of the Senate Democratic leadership, the senior Senator from New York, made it crystal clear the Senate Democratic leadership would pull the plug. That member, who is very smart and articulate, made it as transparent as possible that the September 15 deadline was more important than a bipartisan deal.

I ask you to go back and look at the media reports. The Gang of 6 was unable to reach a deal on contentious issues such as abortion, the individual mandate, and financing issues by White House/Democratic leadership's deadline.

Chairman BAUCUS had to move forward. I respect the pressure my friend from Montana was under. I have been there myself. But the record needs to be correctly made that the September 15 deadline was not a Republican deadline. It was a deadline imposed by the White House and the Senate Democratic leadership. I might say that wasn't just the GOP deadline—it wasn't a deadline for the Gang of 6 either. I didn't sense, from the three Democratic members, that they agreed with that.

So the Senate Democratic leadership pulled the plug on the talks. Again, go check the public comments and press reports. They pulled the plug. Senator ENZI and I could not agree to the product at that point because of substantive issues that were resolved against us and the failure of the White House or Senate Democratic leadership to deliver on those process assurances that we asked for.

Senator SNOWE did have substantive issues resolved sufficiently at the Finance Committee markup so that she could support the bill.

I might note today that I heard Senator SNOWE caution the Democrats as she gave them the boost from her vote in the Finance Committee—that was right after the bill passed—she made it clear that her vote for later stages would depend in part on data on the key question of whether the product makes health care more affordable. Her letter to CBO dated December 3 lays out the issues in precision.

At the next stage of the process, the merged-bill stage, all of the Senate Republicans' worst fears were confirmed, but it was especially telling to Senator ENZI and me. My sense is Senator SNOWE appreciated it more than any other member of our conference. The bottom line was that the majority leader's merged bill was constructed in such a partisan way that Senator SNOWE's input was cast aside.

Let's be clear. Senate Republicans did not set deadlines. Senate Republicans did not threaten to go their own way if the deadlines were not met. Even today, the pending motion from this side of the aisle puts the question to the Senate this way: Take the bill back to the Finance Committee.

As the old saying goes, hindsight is 20/20. As I look back on the process, I make these observations: There was an uncanny disconnect between those inside and outside the room. Many on the outside, mainly from the left side of the political spectrum, seemed to want a reform deal just to have a deal. They did not seem to be that curious about the contents. Perhaps for some of those folks, it was a bit of an imperative to draw on the good will that any President has in the first few months of office.

For those of us in the room—meaning the room where the negotiations were going on—there was a realization that we were tackling, as Chairman BAUCUS has described it, an extremely complex set of issues. We learned very quickly that closing the loop on the policy issues, let alone finding political consensus, was not easy.

The pressure to close a deal by the July 4 recess was overwhelming. My friend, the chairman, wisely pushed back and said we would get a deal when we reached a bipartisan deal. The Group of 6 was unable to reach a deal on contentious issues such as abortion, individual mandate, and financing issues faced by the White House-Democratic leadership deadline. Chairman BAUCUS had to move. In my heart, I feel he would rather not have had that sort of pressure or make that decision. But that was not our deadline. It was a deadline imposed by the White House and the Senate Democratic leadership. They pulled the plug on the talks. Go check the public comments and the press reports. They pulled the plug. Senator ENZI and I could not agree to a product at that point because of the substantive issues that were very much involved.

I want to make it very clear, for this Senator, of the three Republicans who were negotiating, kind of in summary, that the Republican leadership, I think, had questions about a lot of things that were going on in those negotiations. But never once did Senator MCCONNELL, my leader, say to me: Get out of there.

That is the impression that was left this morning.

I can only say that I think I have established a reputation in the Senate, particularly while I was chairman of the Senate Finance Committee, that I did not listen to either the White House or people in leadership necessarily when I thought a bipartisan compromise was the only way to get things done. I suppose there is a whole long list of things that I ought to write down before I make this statement, but I can only think of two or three right now that I can be sure of that I can say in an intellectually honest way that I stood up to the Bush White House when I was chairman of the committee.

They came out immediately for a $1.7 trillion tax cut in 2001. I made a decision early on that it was not good for the economy and it was not politically possible. So we passed a much smaller, in a bipartisan way, tax bill for that year. And yet it was the biggest tax cut in the history of the country.

In 2003, when the White House and House Republicans in the majority at that time said we had to have a $700 billion tax cut in addition to the tax cut that was passed in 2001, there were not votes in the Senate among just Republicans to get it done. To secure the votes to get it done, we had to limit it to half that amount of money, or just a little bit more than half that amount of money. And in order to get those votes, contrary to the $700 billion tax cut that the Bush White House wanted and the House Republicans wanted that we could not get through here, I said I will not come out of conference with a tax cut more than that amount of roughly $300 billion.

We got that done by just the bare majority to get it done. But I stood up to the White House, I stood up to the House Republican leadership who thought we should not be doing anything that was short of that full $700 billion.

There have been other health care bills very recently where I stood up against the White House and against our Republican leadership.

I think I have developed a reputation where I am going to do what is right for the State of Iowa and for our country. And I am going to try to represent a Republican point of view as best I can, considering first the country and my own constituency.

Then when it comes to whether people in this body or outside of this body might think that for the whole months of May, June, and July, and through August, with a couple meetings we had during the month of August, that we were dragging our feet to kill a health care reform bill, I want to ask people if they would think I wouldn't have better things to do with my time than to have 24 different meetings, one on one with Chairman BAUCUS, or that I wouldn't have more than something else to do than have 31 meetings with the Group of 6. These were not just short meetings. These were meetings that lasted hours. There was another group of people—GRASSLEY, BAUCUS, and others, sometimes that included people from the HELP Committee and the Budget Committee. But we had 25 meetings like that. I wonder if people think we would just be meeting and spending all those hours to make sure that nothing happened around here. No. Every one of the 100 Senators in this body, if you were to ask them, would suggest changes in health care that need to be made. Even in that 2,074-page bill, there are some things that most conservative people in this country would think ought to be done.

We all know to some extent something has to be done about this system. We worked for a long period of time, thinking we could have something bipartisan. But it did not work out that way, and now we are at a point where we have a partisan bill.

That is not the way you should handle an issue such as health care reform. Just think of the word ''health,'' ''health care.'' It deals with the life and death of 306 million Americans. Just think, you are restructuring one-sixth of the economy.

Senator BAUCUS and I started out in January and February saying to everybody we met, every group we talked to, that something this momentous ought to be passing with 75 or 80 votes, not just 60 votes. Maybe one of the times the White House decided to pull the plug on September 15 may have come on August 5 when the Group of 6 had our last meeting with President Obama. He was the only one from the White House there and the six of us. It was a very casual discussion.

I said this before so I am not saying something that has not been said. But President Obama made one request of me and I asked him a question. For my part, I said: You know, it would make it a heck of a lot easier to get a bipartisan agreement if you would just say you could sign a bill without a public option. That is no different than what I said to him on March 5 when I was down at the White House, that the public option was a major impediment to getting a bipartisan agreement. Then he asked me would I be willing to be one of three Republicans, along with the rest of the Democrats, to provide 60 votes. My answer was upfront: No. As I told him, you can clarify with Senator BAUCUS sitting right here beside you, that 4 or 5 months before that, I told Senator BAUCUS: Don't plan on three Republicans providing the margin, that we were here to help get a broad-based consensus, as Senator BAUCUS and I said early on this year, that something this massive ought to pass with a wide bipartisan majority.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. BENNET). Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I need to correct the RECORD. In the part of my statement where I refer to the July 8 meeting with Senator REID, it was only SNOWE, GRASSLEY, and ENZI, not the other Senators I named. So I wish to correct that for the RECORD.

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

The Senator from Illinois.

MORNING BUSINESS

Mr. DURBIN. 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.

DNA SAMPLING

Mr. KYL. Mr. President, I ask unanimous consent that the following letter, which consists of my May 19, 2008, comments on proposed Federal regulations governing the collection of DNA samples from Federal arrestees and illegal-immigrant deportees, be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, May 19, 2008.

Re OAG Docket Number 119

Mr. DAVID J. KARP,
Senior Counsel, Office of Legal Policy, Main Justice Building, Pennsylvania Avenue, NW., Washington, DC.

DEAR MR. KARP: I am writing to comment on the Justice Department's April 18, 2008, proposed regulation for implementing the DNA sample collection authority created by section 1004 of the DNA Fingerprint Act, Public Law 109–162, and by section 155 of the Adam Walsh Act, Public Law 109–248. I am the legislative author of both of these provisions.

Allow me to note at the outset that I have reviewed the proposed regulations and have concluded that they properly implement the authority created by the laws noted above. I do not recommend that you make any changes to the proposed regulations, as I believe that they are consistent with the clear meaning and spirit of their underlying statutory authorization.

The remainder of this letter first comments on the general privacy objections that have been raised by other commenters with regard to the proposed regulations, and then addresses several other criticisms and recommendations that are made in some of those comments.

PRIVACY CONCERNS

The most common criticism leveled against the proposed regulations by other commenters is that the proposed rules pose a threat to individual privacy. The general argument made is that although fingerprints are routinely taken at arrest, DNA fingerprinting is not like ordinary fingerprinting because DNA has the potential to reveal medically sensitive or other private information. This concern usually also is the basis for arguments that the proposed regulations are unconstitutional.

I think that the privacy concern is best addressed by explaining the legal framework governing the operation of the National DNA Index System (NDIS) and the practical realities of DNA analysis.

A number of statutes prescribe privacy restrictions for use of DNA samples. See 42 U.S.C. 14132(b)(3), (c), 14133(b)–(c), 14135(b)(2), 14135e. In general, DNA information is treated like other law-enforcement case file information—its dissemination is prohibited and subject to serious professional and even criminal sanctions. In particular, section 14133(c) of title 42 provides that any person who has access to individually identifiable DNA information in NDIS and knowingly discloses such information in an unauthorized manner may be fined up to $100,000, and any person who accesses DNA information without authorization may be fined up to $250,000 and imprisoned up to one year.

Lab employees are professionals. The notion that they will violate the laws and regulations governing DNA analysis not only requires one to assume that these employees will jeopardize their careers, but also that they will risk criminal fines and even imprisonment. Such fears are not realistic. Indeed, when arguments were made that such violations might occur during the Senate Judiciary Committee's consideration of the Justice for All Act in 2004, I proposed an amendment, which was subsequently enacted into law, to increase the penalties in section 14133(c) for misuse of DNA samples. When I consulted with the Justice Department about my proposal, I was told that the FBI had no objection to the amendment because there was no chance that any lab employee would ever run afoul of the provision.

Let us assume, however, that a rogue lab employee were not deterred by professional and criminal sanctions and were determined to use a DNA sample to discover private information. That lab employee would find that it is virtually impossible for him to use the NDIS system to do so.

Developing a DNA profile from a saliva or blood sample involves three broad steps: (1) the DNA is extracted from the sample; (2) the DNA is copied or amplified at one of the sites on the DNA strand from which the profile will be drawn; and (3) the amplified DNA is processed in a genetic analyzer to produce a DNA profile.

Each law enforcement DNA laboratory has a defined number of staff who have access to DNA samples, the identity of the person who submitted the sample, and DNA analysis equipment. This is currently the universe of people who could hypothetically use collected samples to try to violate someone's privacy. If one of these employees sought to analyze an individual's DNA to find medically sensitive or other private information, he would run into a series of virtually insurmountable practical problems.

First, the 13 sites at which a DNA strand is analyzed for purposes of entry of a profile into the national database are sites that do not reveal any medically sensitive information. The 13 sites were chosen because the sites do not reveal sensitive information, the sites are relatively stable and do not degrade easily, and the sites tend to demonstrate great variation between different individuals (with the exception of identical twins). Even the American Civil Liberties Union's (ACLU) May 19, 2008, comment on the proposed regulations, while speculating that the 13 sites may be found to reveal sensitive information in the future, concedes ''none of the CODIS loci have been found to date to be predictive for any physical or disease traits.''

So our hypothetical rogue lab employee would need to draw a profile of different sites on the DNA strand in order to discover medically sensitive information. This would be extremely difficult to do. The second step of the analysis—amplifying the relevant DNA sites for analysis—requires the use of specialized reagents and equipment to copy the DNA fragments in question.

Once the DNA is amplified, the DNA is pushed through a column that separates out the DNA fragments. The columns used in the lab serve to duplicate DNA for the specific 13 CODIS sites. So our rogue employee would need to purchase a specialized column for duplicating a different type of DNA. Next the employee would need to obtain different reagents for reproducing the DNA that he seeks. Reagents consist of polymerase, certain chemicals, and DNA primers. A primer is a piece of DNA that recognizes its complimentary DNA on a molecule and attaches itself, allowing that part to be reproduced when the remaining reagents are added. Access to primers is extremely limited—our rogue employee couldn't just buy them on the internet or from a medical supply store. Primers usually are only available from the DNA researcher who discovered the DNA gene or site in question. These researchers generally have a proprietary interest in their discovery; they do not publish all of the information necessary to analyze that gene and do not give the necessary primers to others. A lab employee is very unlikely to be able to obtain the necessary information and primers to amplify the DNA that he seeks.

Moreover, even if our hypothetical lab employee were able to copy the DNA in question, he would next need to retrofit the DNA analyzer to draw a profile from that DNA. This would require breaking down, reassembling, and recalibrating the lab equipment, and reprogramming the equipment and software to analyze different DNA sites. This is an extremely complex process and requires specialized software that, again, is generally only available from the researchers who identified the gene in question. The lab employees are not trained to analyze any DNA other than at the 13 sites used in CODIS; to analyze DNA used for medical purposes is a completely different specialization that requires the use of equipment that lab employees have no experience using.

Finally, our hypothetical rogue employee would need to figure out how to do this analysis by himself and would need to account for his use of the equipment. DNA analysis of database samples is an assembly-line process that involves different persons carrying out different steps of the analysis. An employee acting alone would need to come in at night and perform all of the steps by himself. Although usually no employees are in the lab at night, the equipment runs through the night. To use the equipment for a different purpose, the rogue employee would need to shut it down, which itself would lead to an inquiry into why the equipment did not perform a programmed analysis at night. Moreover, the robotics and most of the instruments used in DNA analysis have programmed activity logs that record what process was run on the equipment, and employees must log in it to operate the equipment. Any inquiry into why the equipment was not running at night would immediately reveal that a different process was run on the equipment and would reveal who ran that process.

Although it is not completely impossible, it is extremely unlikely that a lab employee would be able to perform all of these steps on his own, and it is virtually impossible that he would be able to do so without getting caught. Suffice to say that although the NDIS database has existed for 10 years and nearly 6 million offender profiles have been added to that database, and although the lab has been conducting analysis of DNA from criminal suspects and victims for 20 years, there has never been one noted case in which a lab employee has ever made an unauthorized disclosure of DNA information. The risk that lab employees will undertake such acts is not substantial enough to merit consideration in a reasoned analysis of the privacy risks posed by the operation of NDIS.

Finally, it bears weighing the virtually nonexistent risk to privacy posed by NDIS against other potential risks to DNA privacy. Many of the arguments about the privacy threats created by law-enforcement DNA sampling and analysis appear to assume that DNA samples and the information within them could not be accessed in any other way. A quick internet search of the words ''DNA testing,'' however, reveals that there are many private laboratories that offer to the public at large a wide variety of DNA tests for sensitive information. Nor are DNA samples particularly difficult to obtain. Every time an individual spits on the sidewalk, or even drinks from a paper cup and discards it, he leaves a DNA sample behind. Particularly in light of the criminal penalties attached to misuse of the NDIS system, a person determined to analyze another person's DNA for an improper purposes would find much easier sources of DNA than the samples collected by law enforcement, and would have much readier access to DNA analysis than that made possible by law-enforcement laboratories. The incremental threat to DNA privacy posed by the NDIS system is extremely small.

RESPONSE TO OTHER COMMENTERS

A number of other commenters have offered various criticisms of the proposed regulations beyond generalized privacy arguments. Many of these comments are very similar and appear to have been generated by news stories and notices placed by various organizations and publications. Other criticisms and recommendations are unique to particular commenters. The remainder of this letter responds to those criticisms, first addressing the mass comments and then the arguments of particular organizations and individuals.

Constitutionality

The argument that arrestee and illegal-immigrant DNA sampling violates the Fourth Amendment mostly rests on the privacy arguments that are addressed above. It is beyond argument that the Constitution permits arrestees and immigration detainees to be fingerprinted and searched. If the privacy risks posed by law-enforcement DNA sampling are properly understood, there is no constitutionally significant difference between ordinary fingerprinting and DNA fingerprinting. Both are used for the legitimate purpose of biometric identification and neither poses a significant risk to individual privacy.

The physical intrusion necessary to collect a DNA sample is minor and is commensurate with the other types of privacy intrusions endured by arrestees, who are generally subject to search following arrest. Some commenters cite the 1966 Schmerber decision as a benchmark, and note that the court upheld the drawing of a blood sample in that case because the blood was drawn by a medical professional rather than by a police officer. These commenters neglect to mention, however, that the disposable and sterile pinprick kits used to draw blood samples for purposes of DNA analysis are much different from and much less medically invasive than the needle-drawn blood samples of 1966. And cheek swabs present even less of an intrusion. Modern DNA sample-collection techniques present less of a privacy intrusion than do the physical searches that regularly accompany arrest.

Presumption of Innocence

Many commenters argue that DNA profiling of arrestees violates the presumption of innocence that attaches to an arrestee before he is convicted of a crime. Arrestees are presumed innocent, but DNA sampling and analysis does not constitute a finding or judgment of guilt. If biometric identification did constitute such a judgment, then the photographs and fingerprints taken at and kept after arrest also would violate the presumption of innocence. They do not, and neither does DNA sampling.

Disparate Impact

A number of commenters condemn the proposed regulations on the basis that a disproportionate number of members of racial minorities may be subjected to DNA sampling. A disparate effect, however, is not the same thing as discrimination and is not unconstitutional or otherwise proscribed. Nor

could it be. Most laws have some type of disparate effect; it is a rare (if nonexistent) law that affects each racial or ethnic group in the United States in proportion to its percentage of the U.S. population. The proposed regulations are tied an individual's arrest or his detention on account of his illegal presence in this country; they do not discriminate between individuals on account of their race.

Analysis Backlog

Several commenters complain that adding DNA samples of arrestees and detained illegal immigrants to NDIS will increase the number of DNA samples that the FBI lab or private labs used by the FBI must analyze, and that a backlog of samples may result. The FBI lab and other law enforcement authorities, however, have ample discretion to decide which samples should be analyzed first. These commenters suggest that a backlog of samples may hinder investigations, but a murder or rape for which no suspect has been identified would be hindered more by never collecting a DNA sample from the perpetrator than by collecting that sample and analyzing it after a delay. To the extent that these commenters are concerned about the cost of analyzing DNA samples, they should bear in mind the massive costs of the labor-intensive police manhunts for serial murderers and rapists that would be avoided if the perpetrator could be identified through DNA sample collection, and the enormous costs of crime to its victims and to society as a whole.

Outsourcing

Many commenters suggest that the proposed regulations pose a privacy risk by allowing private contractors to aid in DNA sample processing. These private laboratories are subject to a comprehensive system of regulation, however. They also have a powerful incentive to handle samples properly: a lab that fails to do so will lose its contract and will go out of business.

ACLU Letter

In addition to raising arguments addressed above, the ACLU's May 19 comment argues that biological samples should be destroyed after analysis. This recommendation is outside the scope of the proposed regulations, and in any event should be rejected. Biological samples need to be retained in case the technology used for analysis is changed and all existing samples must be reanalyzed, something that has happened once already. Moreover, such samples are used for quality control, and for rechecking a purported match to crime scene evidence without taking a new sample from the suspect identified by the match.

The ACLU argues that collection of DNA from immigration detainees will deepen resentment and hostility among ethnic communities living in or visiting the United States. Few things exacerbate tensions between Americans and foreign visitors to this country more severely, however, than the serious crimes committed in the United States by illegal immigrants. Angel Resendiz, the so-called Railway Killer, was in this country illegal and is believed to have murdered 15 people here (and an untold number in Mexico). Santana Aceves, the so-called Chandler rapist and also an illegal immigrant, sexually assaulted half a dozen young girls in their homes in the Chandler suburb of Phoenix in 2007 and 2008. Both cases ''deepened resentment and hostility'' toward illegal immigrants in this country. And both Resendiz and Aceves would have been identified and their crime sprees likely stopped early had their DNA been taken during one of their earlier deportations. Relations between different groups in this country surely would be bettered rather than worsened has these two men's names not been permitted to become household words in the communities that they targeted.

The ACLU recommends that the proposed regulations ''prohibit comparison of an individual's DNA profile with anything other than the DNA profiles generated from the crime scene evidence for which she [sic] is suspected unless or until that person is convicted.'' This is a proposal to bar the use of arrestee and detainee DNA to make cold-case matches to crime-scene evidence. It is effectively a recommendation to gut the proposed regulations and to abdicate the Justice Department's responsibility to use the authority created by the DNA Fingerprint Act and the Adam Walsh Act. My floor statement commenting on final Senate action on the DNA Fingerprint Act describes the dozens of rapes and murders that could have been prevented in just one American city had arrestee sampling been in place; I offer it as rebuttal to the ACLU's argument that the proposed regulations should not permit arrestee DNA to be used to solve cold-case crimes.

The ACLU suggests that the Justice Department reassess the costs and benefits of broad sampling and consider narrower alternatives. ''Narrower alternatives'' would mean fewer rapes and murders prevented, a cost which alone justifies the proposed regulations.

The ACLU argues that the proposed regulations, by allowing some exceptions to their sampling rules, fail to give individuals adequate notice whether they will be subject to sampling. The proposed rule clearly requires that all federal arrestees and illegal immigrants being deported be sampled. Allowing a few exceptions to this rule for practical and other reasons does not significantly detract from the notice given by the proposed regulations.

The ACLU complains that the proposed rule does not address how to avoid duplicative sampling of the same individual. This is an administrative matter that does not merit attention in the text of the proposed regulation.

The ACLU questions the Justice Department's estimate of the cost of analyzing and storing DNA samples. The Justice Department's estimate is comparable to other estimates of the costs of DNA storage and analysis.

The ACLU concludes that Congress ''doubtless intended that the regulations would address [legal, privacy, and policy] concerns and would limit the DNA sampling to instances where . . . the benefits outweigh the costs.'' I believe that the proposed rule adequately considers these concerns and appropriately exercises the authority given to the Justice Department by Congress.

McLain and Mercer Letter

William McClain and Stephen Mercer, both law professors at the University of the District of Columbia, contend in a May 19, 2008 comment that the proposed regulations should be modified to allow an individual to retain counsel and file a lawsuit before a sample is collected. I urge the Justice Department to reject this recommendation. Any individual wishing to contest the legality of arrestee sampling may challenge such sampling after the fact; the interests at stake are not substantial enough to justify a pre-litigation injunction in the regulations themselves. Such a delay in sampling would also undermine the administration of the proposed system, as it is far easier to collect a sample at booking, when fingerprints and pictures are also taken.

The professors also suggest that the ''reasonable means'' authorized to collect samples be defined more specifically and be defined in the same way for all agencies collecting samples. The different agencies collecting samples have different means at their disposal and deal with different populations of offenders and detainees; it is appropriate that reasonableness should be defined in the context of each agency and by that agency.

The professors also recommend that all DNA processing agreements with private entities specify that all constitutional, statutory, and regulatory federal law requirements that would apply to government processing also apply to private processing. Such a requirement is superfluous, and in any event is unnecessary in light of the comprehensive regulation of private entities processing DNA on behalf of the Federal government.

Center for Constitutional Rights Letter

Aside from arguments addressed above, CCR argues in a May 19, 2008 comment that the proposed regulations would give Homeland Security staff discretion to ''take DNA samples of everyone pulled out of line for questioning at an airport immigration station.'' This is an unreasonable reading of the regulations, which exclude from sampling ''aliens held at a port of entry during consideration of admissibility and not subject to further detention or proceedings.'' The regulation's ''further detention or proceedings'' clearly contemplates more than just minor additional questioning at a port of entry.

Alliance for Democracy and United for Peace and Justice et al.

These two groups submitted comments on May 19, 2008 suggesting that the proposed regulations would inhibit speech because DNA samples would be taken from persons arrested for civil disobedience. A person wishing to criticize the government or communicate other messages has many ways of doing so without committing a crime, and if he chooses to commit a crime, he should be prepared to face the consequences of doing so, including booking, fingerprinting, DNA sample collection, and a fine or imprisonment.

National Lawyers Guild—Columbia Law School

NLG suggests in an April 21, 2008 comment that the proposed regulations be amended to expressly bar DNA sample collection from LPRs until they are ordered removed and their appeals are exhausted. LPRs very rarely find themselves in immigration detention, and when they do so, it is overwhelmingly because they have committed a crime—and therefore would be subject to sampling on that basis. The remaining class of LPRs not subject to sampling is de minimis; their situation does not rise to the level of a matter that needs to be addressed on the face of the proposed regulations.

NLG also suggests that, because of the risk that a citizen may be mistakenly detained in immigration proceedings, no illegal immigrant should be sampled unless his nationality is conceded or proved, or in the alternative that no sampling ought to take place until a final order of removal has been entered. This proposal would substantially defeat administration of illegal-immigrant sampling by precluding sampling as part of the booking process. Moreover, cases in which citizens are mistakenly detained for deportation are extremely rare and are almost always corrected very quickly. The few cases that might occur should be dealt with on a case-by-case basis and do not merit attention in the text of the proposed rule.

NLG also suggests that subsection (b)(1) of the proposed rule suggests that ''the Secretary of Homeland Security could authorize that which is not authorized by Congress''—

apparently LPR sampling, though NLG is unclear on this point. NLG's concern is misplaced. The bar on LPR sampling is implicit in the proposed regulation, which earlier in the same subsection clearly excludes LPRs.

Administrative Office of the United States Courts

The AOC suggests in a May 16, 2008 comment that the word ''agency'' as used in the proposed rule be defined to exempt judicial agencies from the obligation to collect DNA samples from persons facing charges. A person facing Federal charges may have been arrested by state authorities or turned himself in, and therefore may not have had a DNA sample collected by an executive agency during a Federal arrest. I do not recommend that judicial agencies be exempted from the proposed rule, as they may be the only—or at least the first—Federal agency that is in a position to collect a DNA sample from an offender. I see no reason to exempt judicial pre-trial services agencies from the obligation of all parts of the Federal government to carry out those ministerial tasks necessary to the prevention of violent crime.

AOC also notes that the proposed regulation does not identify a system for determining whether an offender's sample is already in NDIS. This is an administrative matter that need not be addressed in the text of the proposed regulation.

Canadian Embassy and MP

The Canadian Embassy and a Canadian Member of Parliament submitted comments on May 19, 2008 posing several questions about the scope of the proposed rules, most of which appear to be based on a misunderstanding that the rule would require sampling of routine Canadian visitors to the United States. The rule exempts persons processed for lawful entry to the United States or held at a port of entry for consideration for admission to the United States, exceptions that address the concerns raised in these comments.

Sincerely,

JON KYL,
U.S. Senator.

FUNDING FOR PEACEKEEPER TRAINING

Mr. LEVIN. Mr. President, I want to speak today in favor of the administration's funding request for the Global Peace Operations Initiative and one of its important components, the Africa Contingency Operations Training and Assistance Program, for which the bill before the Senate, the fiscal year 2010 State-Foreign Operations appropriations bill, includes $96.8 million in funding. These programs, which I have supported in their various forms for more than a decade, are vital tools in helping the United States and nations around the world, but especially in Africa, to contain crises, violence and instability that threaten not only other nations, but also our own.

The Global Peace Operations Initiative, or GPOI, began in fiscal year 2005 as an effort to address worrisome gaps in the world community's ability to support, equip, and sustain a growing number of peacekeeping operations. This initiative comprised, in part, the fulfillment of a U.S. pledge at the June 2004 G–8 summit meeting at Sea Island, Georgia, to train 75,000 new peacekeepers. The GPOI built on and incorporated the Africa Contingency Operations Training and Assistance Program, or ACOTA, which has trained African peacekeepers since 1997. The objective of these programs is to train and equip military units to deploy to peacekeeping operations, many of them in Africa. In addition, GPOI supports efforts to train special ''gendarme'' police units to participate in peacekeeping operations.

Why are these programs so important? I think we all recognize that the world has become a more challenging and less stable place, but we may not recognize just how pronounced regional security problems have become. We do not need to look further than the two largest United Nations peacekeeping operations, in Darfur, Sudan, and in the Democratic Republic of the Congo. Both of these missions were authorized in response to complex regional conflicts. The United Nations, which oversees the majority of peacekeeping operations worldwide, reports that more than 100,000 peacekeepers and police personnel are deployed on peacekeeping operations—a sevenfold increase since 1999. Those troops are deployed in 17 separate operations, nearly half of which are on the African continent.

Through ACOTA and GPOI, the United States has helped to meet the growing demand for peacekeeping personnel. Since its start in 2005 through the end of fiscal year 2009, GPOI has provided training for nearly 87,000 personnel representing more than 50 nations. Appropriately, given the security challenges in Africa, ACOTA is GPOI's biggest initiative. Since 2005, more than 77,000 personnel from about two dozen African nations have received training through the initiative, and almost 14,000 more have received training under ACOTA through other funding sources. To make these numbers more significant, on average, 90 percent of units trained under ACOTA have deployed between 2005 and 2009.

GPOI provides partner nations with the training and equipment they need to perform peacekeeping missions through the UN or regional groups such as the African Union. This training is broad, and appropriately focuses on peacekeeping-specific tasks such as how to operate checkpoints and convoys, maintaining peace by safely disarming potential combatants, protecting refugees and internally displaced persons, developing and following appropriate rules of engagement, and, in some cases, peacemaking operations.

According to a report by the Department of State Inspector General, GPOI training through ACOTA ''is a win-win situation in which minimal numbers of U.S. military troops are involved, African professionalism and capacity are built up, and the participating African troops are rewarded well when deployed.'' Significantly, the IG report states ''that there have been minimal disciplinary problems and no ACOTA trained troops have been cited for atrocities or notable human rights abuses,'' an important sign that the emphasis on adherence to human rights standards and following the UN's rules of engagement has paid off.

The bill before the Senate, the State-Foreign Operations appropriations bill, includes funding for the administration's request of $96.8 million in funding for GPOI in fiscal year 2010. All of this funding is contained in the peacekeeping operations, or PKO, account of the bill. Based on past practice and the demand for peacekeeping in Africa, the Department of State will likely allocate more than half of this funding to ACOTA. Nearly $100 million is a substantial commitment of taxpayer dollars. But the price of failing to fund these important efforts would be far higher.

Our military leaders are particularly supportive of such efforts, with good reason. Admiral Mike Mullen, the Chairman of the Joint Chiefs of Staff, believes the U.S. commitment to aid the peacekeeping efforts of other nations is ''extremely important and cost effective in comparison to unilateral operations these peacekeepers help promote stability and help reduce the risks that major U.S. military interventions may be required to restore stability in a country or region. Therefore, the success of these operations is very much in our national interest.''

I agree with Admiral Mullen. Programs such as GPOI are important not only because they help alleviate suffering around the globe—which they surely do—but also because they are a cost-effective way of managing U.S. security interests.

I am especially pleased that the administration intends to concentrate going forward on strengthening the capability of partner nations to train their own peacekeeping forces. This ''train the trainers'' approach multiplies the impact of U.S. efforts by giving partner nations the ability to sustain their own peacekeeping efforts. Using this model, the State Department plans to assist in the training and equipping of more than 240,000 peacekeepers over the next 5 years. The other focus will be on growing the planning and operational capability of the regional security organizations on the African continent.

There are other steps we should take to make these vital programs more effective, particularly in Africa. Outside that continent, the U.S. military's Geographic Combatant Commands are responsible for much of the day-to-day management of GPOI programs, including contract management. In Africa, however, those tasks have been performed by contractors working for the State Department's Bureau of African Affairs. With the stand-up of U.S. Africa Command, AFRICOM, in 2008, there is now a Combatant Command in place that could take over the same types of management duties performed elsewhere by its sister commands. I believe

the Departments of State and Defense should explore whether such arrangements are advisable. Given the State Department's deep reliance on contractor personnel to manage the ACOTA program and AFRICOM's unique interagency command structure, I believe AFRICOM ought to be given a more significant role in the day-to-day execution of this critical program. Meanwhile, both departments should make efforts to ensure close cooperation between the State Department and AFRICOM personnel so that the taxpayers and partner nations see the maximum bang for the buck because they are a cost-effective way of managing U.S. security interests and supporting U.N. peacekeeping while reserving U.S. troops for other operations.

Having successfully completed the first 5-year phase, GPOI is entering a new phase. I urge my colleagues to support fully the administration's funding request for GPOI. With this money, we can help contain violence and chaos in many of the world's most troubled places. We can reduce the chance for such instability to create direct and immediate threats to our own security. We can enhance the ability of partner nations to maintain the peace in their own sectors of the globe. And we can accomplish all these things with a relatively modest amount of money—an investment with a substantial return, in both human and financial terms.

MESSAGE FROM THE HOUSE

At 11:35 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. 86. An act to eliminate an unused lighthouse reservation, provide management consistency by incorporating the rocks and small islands along the coast of Orange County, California, into the California Coastal National Monument managed by the Bureau of Land Management, and meet the original Congressional intent of preserving Orange County's rocks and small islands, and for other purposes.

H.R. 3603. An act to rename the Ocmulgee National Monument.

H.R. 3951. An act to designate the facility of the United States Postal Service located at 2000 Louisiana Avenue in New Orleans, Louisiana, as the ''Roy Rondeno, Sr. Post Office Building''.

H.R. 4213. An act to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes.

The message also announced that pursuant to section 125(c)(1) of Public Law 110–343, the minority leader appointed from private life Mr. J. Mark McWatters of Texas as a member of the Congressional Oversight Panel on the part of the House.

At 2:32 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on 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.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 86. An act to eliminate an unused lighthouse reservation, provide management consistency by incorporating the rocks and small islands along the coast of Orange County, California, into the California Coastal National Monument managed by the Bureau of Land Management, and meet the original Congressional intent of preserving Orange County's rocks and small islands, and for other purposes; to the Committee on Energy and Natural Resources.

H.R. 3603. An act to rename the Ocmulgee National Monument; to the Committee on Energy and Natural Resources.

H.R. 3951. An act to designate the facility of the United States Postal Service located at 2000 Louisiana Avenue in New Orleans, Louisiana, as the ''Roy Rondeno, Sr. Post Office Building''; to the Committee on Homeland Security and Governmental Affairs.

H.R. 4213. An act to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes; to the Committee on Finance.

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–3966. A communication from the Chairman and President of the Export—Import Bank, transmitting, pursuant to law, a report relative to transactions involving U.S. exports to Hong Kong; to the Committee on Banking, Housing, and Urban Affairs.

EC–3967. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Protection of Stratospheric Ozone: Adjustments to the Allowance System for Controlling HCFC Production, Import, and Export'' (FRL No. 9091–7) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Environment and Public Works.

EC–3968. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Protection of Stratospheric Ozone: Ban on Sale or Distribution of Pre-Charged Appliances'' (FRL No. 9091–9) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Environment and Public Works.

EC–3969. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Clothianidin: Pesticide Tolerances'' (FRL No. 8793–6) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Environment and Public Works.

EC–3970. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Endangerment and Cause or Contribute Findings for Greenhouse Gases Under Section 202(a) of the Clean Air Act'' (FRL No. 9091–8) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Environment and Public Works.

EC–3971. A communication from the Program Manager, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare Program; Changes to the Medicare Claims Appeal Procedures'' (RIN0938–AM73) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Finance.

EC–3972. A communication from the Program Manager, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare Program; Application of Certain Appeals Provisions to the Medicare Prescription Drug Appeals Process'' (RIN0938–AO87) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Finance.

EC–3973. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to the Case-Zablocki Act, 1 U.S.C. 112b, as amended, the report of the texts and background statements of international agreements, other than treaties (List 2009–0213—2009–0223); to the Committee on Foreign Relations.

EC–3974. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the export of defense articles, including, technical data, and defense services to Chile relative to the design and manufacture of the Sig 556 Rifle in the amount of $1,000,000 or more; to the Committee on Foreign Relations.

EC–3975. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 18–238, ''Omnibus Election Reform Amendment Act of 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3976. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 18–239, ''Hospital and Medical Services Corporation Regulatory Amendment Act of 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3977. A communication from the Director, Office of Personnel Management, transmitting, pursuant to law, the Semiannual Report of the Inspector General for the period from April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3978. A communication from the Director, Congressional Affairs, Federal Election Commission, transmitting, pursuant to law, the Semiannual Report of the Inspector General for the period from April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3979. A communication from the Secretary of Education, transmitting, pursuant to law, a report entitled ''Fiscal Year 2009 Agency Financial Report''; to the Committee on Homeland Security and Governmental Affairs.

EC–3980. A communication from the Acting Chief Executive Officer, Millennium Challenge Corporation, transmitting, pursuant to law, the Semiannual Report of the Inspector General for the period from April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, without amendment:

S. 1755. A bill to direct the Department of Homeland Security to undertake a study on emergency communications (Rept. No. 111–105).

By Mr. INOUYE, from the Committee on Appropriations:

Special Report entitled ''Further Revised Allocation to Subcommittees of Budget Totals from the Concurrent Resolution, Fiscal Year 2010'' (Rept. No. 111–106).

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. HARKIN for the Committee on Health, Education, Labor, and Pensions.

*Jacqueline A. Berrien, of New York, to be a Member of the Equal Employment Opportunity Commission for a term expiring July 1, 2014.

*Chai Rachel Feldblum, of Maryland, to be a Member of the Equal Employment Opportunity Commission for a term expiring July 1, 2013.

*P. David Lopez, of Arizona, to be General Counsel of the Equal Employment Opportunity Commission for a term of four years.

*Victoria A. Lipnic, of Virginia, to be a Member of the Equal Employment Opportunity Commission for the remainder of the term expiring July 1, 2010.

*Victoria A. Lipnic, of Virginia, to be a Member of the Equal Employment Opportunity Commission for a term expiring July 1, 2015.

*Adele Logan Alexander, of the District of Columbia, to be a Member of the National Council on the Humanities for a term expiring January 26, 2014.

*Sara Manzano-Diaz, of Pennsylvania, to be Director of the Women's Bureau, Department of Labor.

*Patrick Alfred Corvington, of Maryland, to be Chief Executive Officer of the Corporation for National and Community Service.

*Lynnae M. Ruttledge, of Washington, to be Commissioner of the Rehabilitation Services Administration, Department of Education.

By Mr. LEAHY for the Committee on the Judiciary.

Denny Chin, of New York, to be United States Circuit Judge for the Second Circuit.

Rosanna Malouf Peterson, of Washington, to be United States District Judge for the Eastern District of Washington.

William M. Conley, of Wisconsin, to be United States District Judge for the Western District of Wisconsin.

Paul R. Verkuil, of Florida, to be Chairman of the Administrative Conference of the United States for the term of five years.

Richard G. Callahan, of Missouri, to be United States Attorney for the Eastern District of Missouri for the term of four years.

John Gibbons, of Massachusetts, to be United States Marshal for the District of Massachusetts for the term of four years.

John Leroy Kammerzell, of Colorado, to be United States Marshal for the District of Colorado for the term of four years.

By Mrs. FEINSTEIN for the Select Committee on Intelligence.

*Philip S. Goldberg, of the District of Columbia, to be an Assistant Secretary of State (Intelligence and Research).

*Caryn A. Wagner, of Virginia, to be Under Secretary for Intelligence and Analysis, Department of Homeland Security.

*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.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

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. PRYOR:

S. 2863. A bill to provide that an outbreak of infectious disease or act of terrorism may be a major disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122 et seq.), and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. PRYOR:

S. 2864. A bill to provide for the enhancement of United States preparedness for outbreaks of infectious disease to protect homeland security; to the Committee on Health, Education, Labor, and Pensions.

By Mr. LIEBERMAN (for himself and Ms. COLLINS):

S. 2865. A bill to reauthorize the Congressional Award Act (2 U.S.C. 801 et seq.), and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. BURRIS:

S. 2866. A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to reauthorize the juvenile accountability block grants program through fiscal year 2014; to the Committee on the Judiciary.

By Mrs. MURRAY:

S. 2867. A bill to require the Secretary of the Treasury to provide assistance to community depository institutions under the Public-Private Investment Program, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. LIEBERMAN:

S. 2868. A bill to provide increased access to the General Services Administration's Schedules Program by the American Red Cross and State and local governments; to the Committee on Homeland Security and Governmental Affairs.

By Ms. LANDRIEU (for herself and Ms. SNOWE):

S. 2869. A bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

By Mr. INOUYE (for himself, Ms. SNOWE, Mr. BEGICH, and Ms. MURKOWSKI):

S. 2870. A bill to establish uniform administrative and enforcement procedures and penalties for the enforcement of the High Seas Driftnet Fishing Moratorium Protection Act and similar statutes, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. INOUYE:

S. 2871. A bill to make technical corrections to the Western and Central Pacific Fisheries Convention Implementation Act, and for other purposes; to the Committee on Commerce, Science, and Transportation.

ADDITIONAL COSPONSORS

S. 583

At the request of Mr. PRYOR, the name of the Senator from New Mexico (Mr. UDALL) was added as a cosponsor of S. 583, a bill to provide grants and loan guarantees for the development and construction of science parks to promote the clustering of innovation through high technology activities.

At the request of Mr. JOHANNS, his name was added as a cosponsor of S. 583, supra.

S. 812

At the request of Mr. BAUCUS, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 812, a bill to amend the Internal Revenue Code of 1986 to make permanent the special rule for contributions of qualified conservation contributions.

S. 848

At the request of Mrs. MCCASKILL, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 848, a bill to recognize and clarify the authority of the States to regulate intrastate helicopter medical services, and for other purposes.

S. 864

At the request of Mr. DORGAN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 864, a bill to amend the Internal Revenue Code of 1986 to expand tax-free distributions from individual retirement accounts for charitable purposes.

S. 941

At the request of Mr. CRAPO, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 941, a bill to reform the Bureau of Alcohol, Tobacco, Firearms, and Explosives, modernize firearm laws and regulations, protect the community from criminals, and for other purposes.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1076

At the request of Mr. MENENDEZ, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1129

At the request of Mr. DURBIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1129, a bill to authorize the Secretary of Education to award grants to local educational agencies to improve college enrollment.

S. 1160

At the request of Mr. SCHUMER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1160, a bill to provide housing assistance for very low-income veterans.

S. 1243

At the request of Mr. HATCH, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 1243, a bill to require repayments of obligations and proceeds from the sale of assets under the Troubled Asset Relief Program to be repaid directly into the Treasury for reduction of the public debt.

S. 1439

At the request of Mr. WYDEN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 1439, a bill to provide for duty-free treatment of certain recreational performance outerwear, and for other purposes.

S. 1932

At the request of Mr. BENNET, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 1932, a bill to amend the Elementary and Secondary Education Act of 1965 to allow members of the Armed Forces who served on active duty on or after September 11, 2001, to be eligible to participate in the Troops-to-Teachers Program, and for other purposes.

S. 2747

At the request of Mr. BINGAMAN, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of S. 2747, a bill to amend the Land and Water Conservation Fund Act of 1965 to provide consistent and reliable authority for, and for the funding of, the land and water conservation fund to maximize the effectiveness of the fund for future generations, and for other purposes.

S. 2755

At the request of Mr. MENENDEZ, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 2755, a bill to amend the Internal Revenue Code of 1986 to provide an investment credit for equipment used to fabricate solar energy property, and for other purposes.

S. 2796

At the request of Mr. ENZI, the names of the Senator from Nebraska (Mr. JOHANNS) and the Senator from Mississippi (Mr. WICKER) were added as cosponsors of S. 2796, a bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes.

S. 2816

At the request of Mr. BUNNING, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2816, a bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs and to allow the adoption credit to be claimed in the year expenses are incurred, regardless of when the adoption becomes final.

S. 2853

At the request of Mr. GREGG, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 2853, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans.

At the request of Mr. CONRAD, the name of the Senator from Virginia (Mr. WEBB) was added as a cosponsor of S. 2853, supra.

S. RES. 316

At the request of Mr. MENENDEZ, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

AMENDMENT NO. 2789

At the request of Mr. COBURN, the name of the Senator from New Mexico (Mr. UDALL) was added as a cosponsor of amendment No. 2789 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. 2793

At the request of Mr. BEGICH, his name was added as a cosponsor of amendment No. 2793 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 Maryland (Ms. MIKULSKI), the Senator from Colorado (Mr. UDALL) and the Senator from Ohio (Mr. BROWN) were added as cosponsors of amendment 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. 2909

At the request of Mr. NELSON of Florida, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor 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. 2923

At the request of Mr. DORGAN, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Minnesota (Ms. KLOBUCHAR) were added as cosponsors 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. 2928

At the request of Mr. CASEY, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of amendment No. 2928 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. 2938

At the request of Mrs. GILLIBRAND, the name of the Senator from New Hampshire (Mrs. SHAHEEN) was added as a cosponsor of amendment No. 2938 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. 2947

At the request of Ms. KLOBUCHAR, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of amendment No. 2947 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 names of the Senator from New York (Mr. SCHUMER) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors 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. 3011

At the request of Ms. LANDRIEU, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of amendment No. 3011 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. 3030

At the request of Mrs. FEINSTEIN, the names of the Senator from California (Mrs. BOXER) and the Senator from Rhode Island (Mr. REED) were added as cosponsors of amendment No. 3030 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. 3046

At the request of Mr. KERRY, the names of the Senator from New Hampshire (Mrs. SHAHEEN) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of amendment No. 3046 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. 3051

At the request of Mr. BARRASSO, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of amendment No. 3051 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. 3069

At the request of Mr. KOHL, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of amendment No. 3069 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. 3071

At the request of Mrs. HAGAN, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of amendment No. 3071 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. 3085

At the request of Mrs. LINCOLN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 3085 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. 3102

At the request of Mr. DURBIN, the names of the Senator from Illinois (Mr. BURRIS) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of amendment No. 3102 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. PRYOR:

S. 2863. A bill to provide that an outbreak of infectious disease or act of terrorism may be a major disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122 et seq.), and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. PRYOR. Mr. President, I rise today to introduce two pieces of legislation to address gaps in our preparedness and ability to respond to widespread infectious disease outbreaks and biological attacks.

The H1N1 outbreak demonstrated to us how investments in pandemic preparedness activities, such as the creation of pandemic influenza strategies, can lessen the effects of a pandemic and improve our response. However, we have learned from the H1N1 pandemic that we still have gaps in our ability to prepare for and respond to these types of events and that state and local entities are uncertain in their abilities to respond to a more severe event.

Apart from shortcomings in government coordination and planning, there is also a glaring deficiency in an important statute that underpins our nation's response to disasters. When a natural disaster such as flooding in Arkansas occurs, local and State government resources can be quickly overextended. When that occurs a governor can request and the President can issue a major disaster declaration, which triggers the maximum amount of resources from the Federal disaster response system.

Sometimes the system works well and other times not as well, but we know for certain that without a disaster declaration and effective Federal intervention a natural disaster can have devastating effects on life, property, and our economy.

Unfortunately, due to a lack of clarification of the definition of a major disaster in the Stafford Act, there is no precedent for the President to issue a major disaster declaration when local medical resources are overwhelmed by the exponential spread of life-threatening diseases, or alternatively, a deliberate biological attack by terrorists. The bills that I am introducing today will help to address preparedness shortcomings as well as the deficiency in law.

My first bill, S. 2863, entitled The Emergency Response Act, addresses this shortcoming in law. It will ensure the Federal Government can provide the maximum amount of support to State and local governments by allowing pandemics, acts of terrorism or other man-made disasters to be considered a major disaster under the Stafford Act. This clarification in law will permit the President to issue a major disaster declaration and allow Federal agencies to coordinate their efforts, give technical assistance, give advisory assistance, and work with local authorities and people in the private sector for events such as pandemics, biological attacks or chemical releases.

The second bill, S. 2864, entitled The Defense Against Infectious Disease Act, requires the Federal government to periodically update the National Strategy for Pandemic Influenza and the National Pandemic Implementation plan with the assistance of State, Local and Tribal stakeholders in order to ensure our preparedness plans are up to date and incorporate the latest technologies, medical developments and logistical challenges.

This bill addresses concerns raised by the U.S. Government Accountability Office about both the completeness of these emergency plans and the need for them to be updated. Most Americans may not even know that these emergency plans exist, but they do understand that strong planning is the foundation for effective action. An out-of-date plan is not a plan, and after watching the spread of H1N1 and the missteps in our government's response, Americans can easily imagine what it would be like in the event of an even more serious disease outbreak, and the importance of planning for such an emergency.

This bill will also help address the situation I described previously in which a severe infectious disease outbreak can overwhelm our local medical facilities, many of which have limited resources to handle even their every day needs. To address situations which will over extend local resources, my bill also requires the Federal Government to identify alternative medical care facilities and other resources such as medical equipment, daily supplies and personnel to ensure we know what assets we have to help State and local communities.

The idea here is preparation. We should make the best of the H1N1 outbreak and learn from this experience. That is why I introduced the Emergency Response Act and the Defense Against Infectious Diseases Act. I ask that my colleagues support these bills to ensure that we are prepared for the next pandemic.

Mr. President, I ask unanimous consent that a bill summary be printed in the RECORD.

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

EMERGENCY RESPONSE ACT OF 2009 SUMMARY

The Emergency Response Act of 2009 is intended to improve response to infectious disease outbreaks, acts of terrorism and other disasters.

Section 2 of the legislation amends the Robert T. Stafford Disaster Relief and Emergency Assistant Act to provide that a pandemic, act of terrorism or other manmade disaster be considered a trigger to issue a ''major disaster'' declaration under the Act. Section 3 creates a working group under the auspices of the Secretary of Homeland Security to prepare recommendations for facilitating the dissemination of public health information to State fusion centers and the greater homeland security community.

DEFENSE AGAINST INFECTIOUS DISEASES ACT OF 2009 SUMMARY

The Defense Against Infectious Disease Act of 2009 is intended to address gaps in preparedness in the event of a significant outbreak of an infectious disease.

Section 3 of the legislation directs that a consortium of state, local, and tribal representatives be convened to assess the adequacy of existing guidance and support in the National Strategy for Pandemic Influenza and National Strategy for Pandemic Influenza Implementation plans. Section 4 directs the Secretary of Health and Human Services in coordination with the Secretary of Homeland Security to identify alternative medical care facilities and resources available to locate and distribute both medical and non-medical supplies to support communities over extended by an infectious disease outbreak. Section 5 directs GAO to prepare a report describing the roles and responsibilities, capabilities and coordination of federal government assets in place across various departments for responding to infectious disease outbreaks and biological attacks.

By Ms. LANDRIEU (for herself and Ms. SNOWE):

S. 2869. A bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

Ms. LANDRIEU. Mr. President, our Nation's small businesses have created 64 percent of all new jobs in the last 15 years, yet in the last year nearly 85 percent of the jobs lost have come from small businesses. To reverse this job loss trend and allow small businesses to be the engine of economic growth once again, we must make sure they have the access to capital they need to be successful and help grow our economy.

That is exactly why I, along with the ranking member of the Small Business Committee, OLYMPIA SNOWE of Maine, am introducing the Small Business Job Creation and Access to Capital Act of 2009. This bipartisan legislation is a result of five hearings and roundtables in the Small Business Committee this year as well as numerous meetings with small business owners. It builds off of S. 1832, the Small Business Access to Capital Act of 2009, and S. 1615, the Next Step for Main Street Credit Availability Act of 2009, legislation Senator SNOWE and I have previously introduced.

This legislation enhances the ability of the SBA to support larger loans and provide more options to small businesses. As many other sources of capital have evaporated, loans guaranteed by the SBA, with support of funding through the Recovery Act, have been able to support $16.5 billion in loans to small businesses. Specifically, this act would: increase the loan limit on 7(a) loans from $2 million to $5 million; increase the loan limit on 504 loans from $1.5 million to $5.5 million; increase the loan limit on microloans from $35,000 to $50,000, as well as increase the loan limit to microloan intermediaries from $3.5 million to $5 million; allow the 504 loan program to refinance short-term commercial real estate debt into long-term, fixed rate loans; extend the authorization to provide 90 percent guarantees on 7(a) loans and fee elimination for borrowers on 7(a) and 504 loans through December 31, 2010; and direct the SBA to create a website where small businesses can identify lenders in their communities.

These provisions will have an immediate impact on increasing the availability of credit for small businesses and spurring job growth, with many of these provisions coming at little or no cost to the government. For example, the SBA estimates that the loan limit increases will be budget neutral, but will increase SBA lending by $5 billion next year alone. The refinancing provisions could help save 60,000 jobs next year by allowing small businesses to refinance short-term commercial real estate debt into long-term fixed rate mortgages. To ensure that this program is budget neutral we have included a provision that would require any additional cost created by the program to be funded by the fees of the participants. Additionally, we have placed a number of safeguards on this program, such as requiring that the refinanced loan be current for at least one year, that the business owner invest a minimum of 20 percent equity and that the availability of funds be capped at $65,000 for every job retained.

The extension of the 90 percent guarantees on 7(a) loan and the fee elimination for borrowers on traditional 504 and 7(a) loans extends critical provisions in the Recovery Act. This legislation does not include the appropriations for this funding, but does provide an extension of its authorization should appropriations be made available. It is estimated that if an additional $479 million were to be appropriated for these programs, the SBA would be able to support $18.5 billion in lending to small businesses. Alternately, we are starting to see the impact of this funding not being available. In the first full week of lending since the SBA had to create a waiting list for the final Recovery Act funding, 7(a) loan volume fell from $985 million in the last week of the full funding being available, to $71 million. This $71 million in loan volume is lower than the average weekly volume we were experiencing before the Recovery Act was approved. We also know that as of today there are more than 700 small businesses in the SBA waiting list approved for $350 million in loans if we made more funding available.

It is clear that now is the time to act. Our Nation's small businesses need access to capital and this bill helps facilitate this crucial need.

Ms. SNOWE. Mr. President, we all know the statistics are bleak. Unemployment is at 10 percent, more than 7 million Americans have lost their jobs since the start of this current recession, and the National Federation of Independent Businesses' Optimism Index, a compilation of 10 survey indicators, is at 88.3, a number the NFIB calls ''stuck at recession levels.'' These statistics, and the stories they represent present Congress with myriad challenges including: What will we do to lower unemployment, create jobs, and help our small businesses to grow again?

The legislation Chair LANDRIEU and I are introducing today, the Small Business Job Creation and Access to Capital Act of 2009, aims to meet this challenge and takes the best ideas from Republicans and Democrats, to help put American small businesses back to work. I would especially like to thank the Chair for working with me in such an open manner in developing this bill. Creating jobs and helping small businesses should not be a partisan issue and the Chair has been extremely open to my suggestions, incorporating many of the provisions I originally introduced in the Small Business Lending Improvement Act, the 10 Steps for a Main Street Economic Recovery Act, and the Next Step for a Main Street Economic Recovery Act into this legislation.

In the past year, one cornerstone of small business recovery has been Small Business Administration, SBA, backed lending. Last year, to help address the chronic shortage of capital for small business borrowers, I introduced the 10 Steps for a Main Street Economic Recovery Act. Many of the provisions in this legislation were included in the American Recovery and Reinvestment Act and some have been credited with helping to increase SBA loan volume 79 percent.

One provision which has been extremely popular has been fee reductions for 7(a) and 504 loans. In fact, at a round table on reauthorizing the SBA's access to capital programs the Senate Committee on Small Business and Entrepreneurship heard from Mr. Michael Heath, the owner of Ramunto's Brick Oven Pizza in St. Johnsbury, Vermont. Mr. Heath told the Committee that the funds he saved in SBA fee reductions helped him buy his pizzeria. The bill we are introducing today would extend the fee reductions I originally proposed in 10 Steps to December 31st, 2010. This critical step ensures that we can continue to help entrepreneurs like Mike open businesses on Main Streets across America.

Another vital provision contained in this legislation expands the number of

businesses eligible for SBA-backed loans and expands the size of those loans. I originally proposed this idea in the Small Business Lending Improvement Act which calls for an alternative size standard that would help more small businesses meet the SBA's requirements to access SBA-backed loans, and also included it in the Next Step for Main Street Credit Availability Act, which includes provisions allowing borrowers to take out larger 7(a) loans, microloans, and 504 loans. President Obama has also recognized the need for larger loan sizes and has advocated for this position as a way to create jobs and help small businesses.

Underscoring the inadequate size of SBA loans, I heard testimony earlier this year at a field hearing Senator SHAHEEN and I held in Portland, Maine from Mr. Richard Pfeffer, a local business owner, on how small SBA loan sizes have directly impacted his business. Mr. Pfeffer testified that his two businesses, Aroostook Starch and Gritty McDuff's, a restaurant and pub regarded by many as a Portland landmark, were close to bankruptcy not because of the economic downturn, but rather because of his inability to access larger SBA loans. Mr. Pfeffer is still in business today, and Gritty's is now serving its famous Christmas Ale, but his inability to access capital still looms and it is costing him the opportunity to expand his business and hire more workers. The increased loan limits in this bill would help Mr. Pfeffer and others like him to put the American economy back on track.

This bill also includes another provision I proposed in March and introduced in my Next Steps legislation that would allow SBA borrowers to shop and compare SBA loan rates online, offering borrowers the opportunity to make an informed choice and save time and money.

Finally, the Small Business Job Creation and Access to Capital Act of 2009 would allow borrowers of 504 loans to refinance their debt. This provision will give borrowers critical working capital that they can use to grow and expand their businesses.

These targeted reforms will help put Americans back to work, ease the capital crunch for small businesses, and help bring SBA lending into the future. I urge my colleagues to support this critical legislation to improve America's economy and increase small business lending.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3115. 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.

SA 3116. Mr. WYDEN (for himself, Ms. COLLINS, 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 3117. Mr. WYDEN (for himself, Ms. COLLINS, 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 3118. Ms. COLLINS (for herself, Mr. WYDEN, 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 3119. Mr. WARNER (for himself, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mrs. SHAHEEN, Mrs. HAGAN, Mr. MERKLEY, Mr. BEGICH, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNET, Mrs. GILLIBRAND, Mr. FRANKEN, Mr. KIRK, Ms. COLLINS, Ms. KLOBUCHAR, 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, supra; which was ordered to lie on the table.

SA 3120. Mr. CRAPO 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 3121. Mr. CRAPO 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 3122. Mr. CRAPO 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 3123. Mr. CRAPO 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 3124. Mr. CRAPO 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 3125. Mr. CRAPO 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 3126. Mr. CRAPO 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 3127. Mr. MERKLEY (for himself and Mrs. MURRAY) 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 3128. Mr. KOHL 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 3129. Mrs. MURRAY 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 3130. Mr. JOHANNS 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 3131. Mr. KOHL (for himself 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 3132. Mrs. MCCASKILL 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 3133. Mr. WICKER 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 3134. Mr. BURR (for himself, Mrs. HUTCHISON, and Mr. WICKER) 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 3135. Mr. SANDERS (for himself, Mr. BROWN, Mr. FRANKEN, and Mr. BURRIS) 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 3136. Mr. UDALL of New Mexico 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 3137. Mr. BEGICH 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 3138. Mrs. HUTCHISON (for herself and Mr. HATCH) 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 3139. Mrs. HUTCHISON 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 3140. Mrs. HUTCHISON 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 3141. Mrs. HUTCHISON 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 3142. Mrs. HUTCHISON 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 3143. Mrs. HUTCHISON 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 3144. Mr. FRANKEN 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 3145. Mr. MCCONNELL (for himself, Mr. ENSIGN, and Mr. MCCAIN) 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 3146. 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, supra; which was ordered to lie on the table.

SA 3147. 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, supra; which was ordered to lie on the table.

SA 3148. 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, supra; which was ordered to lie on the table.

SA 3149. 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, supra; which was ordered to lie on the table.

SA 3150. 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, supra; which was ordered to lie on the table.

SA 3151. 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, supra; which was ordered to lie on the table.

SA 3152. 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 3153. 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, supra; which was ordered to lie on the table.

SA 3154. 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, supra; which was ordered to lie on the table.

SA 3155. 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, supra; which was ordered to lie on the table.

SA 3156. Mr. LAUTENBERG (for himself, Mr. CARPER, and Mr. MENENDEZ) 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 3157. Mrs. SHAHEEN (for herself and Mr. MERKLEY) 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 3158. 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, supra; which was ordered to lie on the table.

SA 3159. 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, supra; which was ordered to lie on the table.

SA 3160. Mr. BEGICH 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 3161. 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, supra; which was ordered to lie on the table.

SA 3162. Mr. SPECTER (for himself and 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 3163. 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, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3115. 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 1609, after line 23, insert the following:

SEC. 6108. COMMUNITY INTEGRATED NURSING CARE HOMES DEMONSTRATION PROGRAM.

(a) SHORT TITLE.—This section may be cited as the ''Community Integrated Nursing Care Homes Demonstration Program Act'' or the ''CINCH Demonstration Program''.

(b) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish the CINCH demonstration program to test the viability of multiple small house nursing homes that are embedded within residential neighborhoods and collectively certified to provide services through a single eligible operating entity in order to reduce administrative costs and provide related cost savings to the Medicare and Medicaid programs.

(2) DURATION AND SCOPE.—

(A) DURATION.—The Secretary shall conduct the CINCH demonstration program for a period of 5 years.

(B) SCOPE.—The Secretary shall select not more than 6 sites (as described in paragraph (3)) to participate in the CINCH demonstration program, with each site to be operated by a different eligible operating entity (as described under subsection (c)(2)) and not less than 2 sites to be located in rural areas.

(3) SITES.—

(A) IN GENERAL.—A site shall consist of not less than 2 locations, with each location containing not more than 2 small house nursing homes, that are operated by an eligible operating entity under such entity's nursing home license and provider certification.

(B) LOCATIONS.—

(i) DISTANCES.—Distances between locations within a site may vary based upon market demand and availability, with maximum distances between locations to be established by the eligible operating entity based upon the ability of such entity to—

(I) deliver required services and supervision in a timely and appropriate manner; and

(II) subject to paragraph (5), meet all applicable statutory and regulatory requirements for operation of a nursing home.

(ii) ADJOINING PARCELS.—A location shall—

(I) consist of a single parcel of land or multiple adjoining parcels of land; and

(II) be separate from any other location and operate on a non-adjoining parcel of land from such location.

(C) NUMBER OF SMALL HOUSE NURSING HOMES PER SITE.—A site shall contain not less than 4 small house nursing homes and not greater than—

(i) in rural areas (or a site that encompasses a rural area), 12 small house nursing homes; or

(ii) in urban or suburban areas, 24 small house nursing homes.

(4) CONTINUATION OF TREATMENT AS SINGLE PROVIDER.—The Secretary shall develop a process to allow a site, following the 5-year period for the CINCH demonstration program, to continue operation through a single operating entity and receive certification as a single provider for purposes of Medicare and Medicaid, including provisions to permit such continuation following a change in ownership of a participating small house nursing home.

(5) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI, XVIII, and XIX of the Social Security Act as may be necessary to carry out the CINCH demonstration program and shall develop a process that permits sites to be certified and reimbursed under Medicare and Medicaid.

(c) SELECTION.—

(1) TECHNICAL ASSISTANCE PROVIDER.—

(A) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary, through a request for proposal process, shall select a technical assistance provider that shall be responsible for assisting and monitoring eligible operating entities (as described under paragraph (2)).

(B) MINIMUM REQUIREMENTS.—In selecting the technical assistance provider, the Secretary shall ensure that such organization—

(i) is a national not-for-profit organization that is in good standing;

(ii) has a consistent, clearly articulated, and research-based model for operation of small house nursing homes;

(iii) has not less than 10 years of experience in providing development, operation, regulatory, policy, and financial consulting services to clients or partners seeking to innovate the provision of long-term care;

(iv) has demonstrated a successful process and record (for not less than 4 years) for selection and assistance of multiple organizations in implementation of a small house nursing home model, including development, operations, and staff training;

(v) has established curricula for training of leadership, clinical, and direct care staff;

(vi) has demonstrated capacity, through its own resources and consultants, to—

(I) collect Minimum Data Set (''MDS'') information and financial data from eligible operating entities; and

(II) benchmark and analyze such financial data on not less than a quarterly basis;

(vii) has the ability to administer the CINCH demonstration program without additional funding from Federal, State, or local governmental sources;

(viii) agrees to provide technical assistance services to eligible operating entities for a fee that is not greater than its usual and customary fee for such services; and

(ix) agrees to maintain a provider network for small house nursing homes participating in the CINCH demonstration program for a fee that is not greater than its usual and customary fee for such services.

(C) PREFERENCES.—In selecting the technical assistance provider, the Secretary shall give preference to an organization that has demonstrated experience in related business activities, including community-based care models, health care financing, and demonstration programs.

(2) ELIGIBLE OPERATING ENTITY.—

(A) IN GENERAL.—Selection of eligible operating entities shall be determined by the technical assistance provider through a request for proposal process on a continual basis.

(B) MINIMUM REQUIREMENTS.—An eligible operating entity seeking to participate in the CINCH demonstration program shall be required to—

(i) commit to maintaining the small house nursing home requirements described under subsection (d) and permit the technical assistance provider to conduct periodic evaluations to ensure adherence to such requirements;

(ii) maintain membership in a small house nursing home provider network that is maintained by the technical assistance provider; and

(iii) ensure that, for each site, at least 30 percent of the total capacity developed under the CINCH demonstration program is provided to residents that are receiving nursing home benefits under Medicaid.

(d) SMALL HOUSE NURSING HOME REQUIREMENTS.—To be eligible to participate in the CINCH demonstration program, a small house nursing home shall—

(1) subject to subsection (b)(5), have been certified by a State or local entity (in accordance with applicable State and local law) to operate a nursing home;

(2) operate in compliance with any direct care and certified nurse assistant staffing requirements under Federal and State law;

(3) provide nursing home services, as required under State law and applicable licensing standards, that shall not be less comprehensive or high-acuity than services provided by the eligible operating entity within the immediate surrounding community;

(4) provide for meals cooked in the small house nursing home and not prepared in a central kitchen and transported to the nursing home;

(5) provide for a universal worker approach to resident care (such as a certified nursing assistant who provides personal care, socialization services, meal preparation services, and laundry and housekeeping services);

(6) provide for direct care staffing at a rate of not less than 4 hours per resident per day, with direct care staff (including certified nurse assistants) to be onsite, awake, and available within each nursing home at all times;

(7) provide for direct nursing care at a rate of not less than 1 hour per resident per day, with a nurse to be awake and available at each location at all times (with nurses to be shared between not more than 2 nursing homes on each site) as part of a nursing staff that meets or exceeds applicable Federal and State requirements for qualifications, services, and availability;

(8) provide for any other clinical, operational, management, or facility staff and services as required under applicable Federal and State requirements, with such staff to be available from centralized or distributed locations;

(9) provide for consistent staff assignments and self-directed work teams of direct care staff;

(10) provide training for all staff involved in the operations of the nursing home (for not less than 120 hours for each universal worker and not less than 60 hours for each leadership and clinical team member, to be completed for the majority of the staff before they start to work in a small house nursing home) concerning the philosophy, operations, and skills required to implement and maintain self-directed care, self-managed work teams, a noninstitutional approach to life and care in long-term care, appropriate safety and emergency skills, cooking from scratch by the direct care staff and food handling and safety, and other elements required for successful operation of the nursing home;

(11) ensure that the percentage of residents in each nursing home who are short-stay rehabilitation residents does not exceed 20 percent at any time (unless the small house nursing home is entirely devoted to providing rehabilitation services), except that a long-term resident transferring back to a nursing home after an acute episode and who is receiving rehabilitation services for which payment is made under the Medicare program shall not be counted toward such limitation;

(12) provide the technical assistance provider with MDS information and financial data in a timely manner on a monthly basis; and

(13) consist of a physical environment designed to look and feel like a home, rather than an institution, and that shall—

(A) be designed to serve as a fully independent and disabled accessible house or apartment, with not more than 10 residents within such house or apartment, and that shall only be connected to or share areas that would be generally shared between private homes (such as a driveway) or apartments (such as a lobby or laundry room);

(B) contain residential-style design elements and materials throughout the home that are similar to those in the immediate surrounding community and that do not use commercial and institutional elements and products (such as a nurses' station, medication carts, hospital or office-type florescent lighting, acoustical tile ceilings, institutional-style railings and corner guards, and room numbering and labeling) unless mandated by authorities with appropriate jurisdiction over the nursing home;

(C) provide private, single occupancy bedrooms that are shared only at the request of a resident to accommodate a spouse, partner, family member, or friend, and that contains a full private bathroom that includes, at a minimum, a toilet, sink, and accessible shower;

(D) contain a living area where residents and staff may socialize, dine, and prepare food together that provides, at a minimum, a living room seating area, a dining area large enough for a single table serving all residents and not less than 2 staff members, and an open full kitchen;

(E) contain ample natural light in each habitable space that is provided through exterior windows and other means, with window areas, exclusive of skylights and clerestories, being a minimum of 10 percent of the area of the room;

(F) have a life-safety rating that is sufficient to meet State and local standards for nursing facilities and appropriately accommodate individuals who cannot evacuate the nursing home without assistance; and

(G) contain built-in safety features to allow all areas of the nursing home to be accessible to residents during the majority of the day and night.

(e) NO ADDITIONAL PAYMENT.—The technical assistance provider, as well as any eligible operating entities and participating small house nursing homes, shall not receive any additional payment or reimbursement under the Medicare or Medicaid programs based upon their participation in the CINCH demonstration program.

(f) EVALUATION AND REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of enactment of this Act, the technical assistance provider shall evaluate the performance of each of the sites participating under the CINCH demonstration program and shall submit to Congress and the Secretary a report containing the results of such evaluation.

(2) EVALUATION REQUIREMENTS.—The evaluation shall include an analysis of—

(A) not less than 12 months of MDS information and financial data from at least 10 small house nursing homes; and

(B) results from focus groups or surveys regarding health outcomes for residents and program costs.

(g) DEFINITIONS.—In this section:

(1) CINCH DEMONSTRATION PROGRAM.—The term ''CINCH demonstration program'' means the demonstration program conducted under this section.

(2) MEDICAID.—The term ''Medicaid'' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) MEDICARE.—The term ''Medicare'' means the program for medical assistance established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) NURSING HOME.—The term ''nursing home'' means—

(A) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a))); or

(B) a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a))).

(5) RESEARCH-BASED.—The term ''research-based'' means research that—

(A) has been conducted by an objective researcher or research team that has—

(i) no financial or affiliated organizational interest in the success of the model; and

(ii) expertise in long-term care, with not less than 3 research articles relating to long-term care that have been published in leading peer-reviewed journals;

(B) has been conducted according to generally accepted research practices;

(C) has been published in a leading peer-reviewed journal on aging or long-term care; and

(D) indicates a measurable improvement in multiple aspects of quality of life and care.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) RURAL AREA.—The term ''rural area'' means any area other than an urban or suburban area.

(8) SUBURBAN AREA.—The term ''suburban area'' means any urbanized area that is contiguous and adjacent to an urban area.

(9) URBAN AREA.—The term ''urban area'' means a city or town that has a population of greater than 50,000 inhabitants.

SA 3116. Mr. WYDEN (for himself, Ms. COLLINS, 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, 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 2028, strike lines 9 and 10 and insert the following:

(3) EFFICIENCY ADJUSTMENT BASED ON PREMIUM INCREASES.—

(A) IN GENERAL.—The portion of the fee determined under paragraph (1) with respect to a covered entity for a calendar year which is attributable to net premiums written shall be multiplied by an amount equal to the sum of—

(i) 50 percent, plus

(ii) the applicable percentage.

(B) APPLICABLE PERCENTAGE.—The applicable percentage is a percentage determined by the Secretary in the following manner:

(i) The applicable percentage for the covered entity with the lowest per-capita premium change shall be 0 percent.

(ii) The applicable percentage for the covered entity with the highest per-capita premium change shall be 100 percent.

(iii) The applicable percentage for each other cover entity shall be based on the degree to which the per-capita premium change for such covered entity is greater than the covered entity with the lowest per-capita premium change, except that in determining such amount the Secretary shall ensure that the aggregate fees for all covered entities under this section for the calendar year (after application of this subsection) is equal to $6,700,000,000.

(iv) Notwithstanding clause (iii), the Secretary may reduce the applicable percentage for a covered entity (but not below zero) with respect to any calendar year if the Secretary determines that the amount of the per-capita premium increase for such entity was primarily due to government restrictions on rates, but only to the extent that the amount of the per-capita premium increase was due to such government restrictions, as determined by the Secretary. In the case of any reduction under the preceding sentence, proper adjustment shall be made to the applicable percentages for other covered entities described in clause (iii) such that the aggregate fees for all covered entities under this section for the calendar year (after application of this subsection) is equal to $6,700,000,000. In no case shall any adjustment cause the applicable percentage for any covered entity to exceed 100 percent.

(C) PER-CAPITA PREMIUM CHANGE.—For purposes of this paragraph—

(i) IN GENERAL.—The term ''per-capita premium change'' means, with respect to any calendar year, the excess of—

(I) the per-capita premium amount for the such calendar year, over

(II) the per capita premium amount for the preceding calendar year.

(ii) PER-CAPITA PREMIUM AMOUNT.—The term ''per-capita premium amount'' means, with respect to any calendar year, the total amount of net premiums written with respect to health insurance for any United States health risk for such calendar year divided by the number of United States health risks which are covered under such net written premiums.

(iii) REPORTING.—

(I) IN GENERAL.—Each covered entity shall include in the report required under subsection (g) the number of United States health risks which are covered under net written premiums with respect to health insurance.

(II) PENALTY.—The rules of subsection (g)(2) shall apply to the information required to be reported under subclause (I).

(4) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under this subsection.

SA 3117. Mr. WYDEN (for himself, Ms. COLLINS, 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, 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 164, between lines 2 and 3, insert the following:

SEC. 13___. OPTIONAL FREE CHOICE VOUCHERS.

(a) IN GENERAL.—Any employer may provide a free choice voucher to any employee of such employer, but only if such employer offers free choice vouchers to—

(1) in the case of an offering employer, all employees of such employer who are eligible to participate in an employer-sponsored plan described in subsection (c)(1), and

(2) in the case of any other employer, all employees of the employer.

(b) FREE CHOICE VOUCHER.—

(1) AMOUNT.—

(A) OFFERING EMPLOYERS.—

(i) IN GENERAL.—In the case of an offering employer, the amount of the free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the employee's premium. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

(ii) DETERMINATION OF COST.—The cost of any health plan shall be determined under the rules similar to the rules of section 2204 of the Public Health Service Act, except that such amount may be adjusted for age and category of coverage in accordance with regulations established by the Secretary.

(B) OTHER EMPLOYERS.—In the case of any other employer, the amount of the voucher provided under subsection (a) shall be not greater than the amount equal to the lowest cost bronze plan of the individual market in the rating area in which the employee resides which—

(i) is offered through an Exchange, and

(ii) provides—

(I) in the case of an employee electing self-only coverage, self-only coverage, and

(II) in any other case, family coverage.

(2) USE OF VOUCHERS.—An Exchange shall credit the amount of any free choice voucher provided under subsection (a) to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

(3) PAYMENT OF EXCESS AMOUNTS.—If the amount of the free choice voucher exceeds the amount of the premium of the qualified health plan in which the qualified employee is enrolled for such month, such excess shall be paid to the employee. Any amount paid to the employee under the preceding sentence shall not be taken into account in determining the rate of pay of the employee under the Fair Labor Standards Act of 1938.

(c) OFFERING EMPLOYER.—For purposes of this section, the term ''offering employer'' means any employer who—

(1) offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and

(2) pays any portion of the costs of such plan.

(d) OTHER DEFINITIONS.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(e) ACCELERATED ACCESS TO EXCHANGES.—Notwithstanding section 1312(f)(2)(B)—

(1) beginning in 2015, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange, but only in connection with employers who provide free choice vouchers under subsection (a); and

(2) if a State under paragraph (1) allows issuers to offer qualified plans in the large group market though an Exchange, the term ''qualified employer'' (as defined in section 1312(f)(2)) shall include a large employer that—

(A) provides free choice vouchers to its employees under subsection (a); and

(B) elects to make all full-time employees eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

''SEC. 139D. FREE CHOICE VOUCHERS.

''Gross income shall not include the amount of any free choice voucher provided by an employer under part I of subtitle D of title I of the Patient Protection and Affordable Care Act to the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.''.

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Free choice vouchers.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(g) DEDUCTION ALLOWED TO EMPLOYER.—

(1) IN GENERAL.—Section 162(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''For purposes of paragraph (1), the amount of a free choice voucher provided under part I of subtitle D of title I of the Patient Protection and Affordable Care Act shall be treated as an amount for compensation for personal services actually rendered.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(h) VOUCHER TAKEN INTO ACCOUNT IN DETERMINING PREMIUM CREDIT.—

(1) IN GENERAL.—Subsection (b)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following new flush sentence:

''The amount of any monthly premium under subsection subparagraph (A) and the amount of the adjusted monthly premium for the second lowest cost silver plan under subparagraph (B) shall be reduced by the amount of any free choice voucher provided to the taxpayer under section _____ of the Patient Protection and Affordable Care Act.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2013.

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

''(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—The assessable payment imposed under paragraph (1) shall be reduced (but not below zero) by the amount of any free choice voucher provided to a full-time employee under section ___ of the Patient Protection and Affordable Care Act for any month during which such employee is enrolled in a qualified health plan with respect to which an applicable premium credit or cost-sharing subsidy is allowed or paid with respect to such employee.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

(2) NOTIFICATION REQUIREMENT.—Section 18B(a)(3) of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting ''and the employer does not offer a free choice voucher'' after ''Exchange''; and

(B) by striking ''will lose'' and inserting ''may lose''.

SA 3118. Ms. COLLINS (for herself, Mr. WYDEN, 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, 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 116, between lines 2 and 3, insert the following:

(3) SPECIAL RULE FOR INDIVIDUALS AGE 30 AND OVER NOT ELIGIBLE FOR EXCHANGE CREDITS AND REDUCTIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), an individual who has attained at least the age of 30 before the beginning of a plan year shall be treated as an individual described in paragraph (2) if the individual is not eligible for the plan year for the premium tax credit under section 36B of the Internal Revenue Code of 1986 or the cost-sharing reductions under section 1402 with respect to enrollment in a qualified health plan offered through an Exchange. The preceding sentence shall not apply to an individual if the individual is not eligible for such credit or reductions because the individual is eligible to enroll in minimum essential coverage consisting of coverage under a government sponsored program described in section 5000A(f)(1)(A).

(B) REQUIREMENTS.—Subparagraph (A) shall only apply to an individual if the individual elects the application of this paragraph and such election provides that—

(i) the individual acknowledges that coverage under the catastrophic plan is the lowest coverage available, that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713), and that these cost-sharing expenses could involve significant financial risk for the individual; and

(ii) the individual agrees that—

(I) the individual will not change such coverage until the next applicable annual or special enrollment period under section 1311(c)(5); and

(II) if the individual elects to change such coverage at the time of such enrollment period, the individual may only enroll in the bronze level of coverage.

(4) STATE AUTHORITY.—In accordance with section 1321(d), a State may impose additional requirements or conditions for catastrophic plans described in this subsection to the extent such requirements or conditions are not inconsistent with the requirements under this subsection.

SA 3119. Mr. WARNER (for himself, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mrs. SHAHEEN, Mrs. HAGAN, Mr. MERKLEY, Mr. BEGICH, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNET, Mrs. GILLIBRAND, Mr. FRANKEN, Mr. KIRK, Ms. COLLINS, Ms. KLOBUCHAR, 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 1134, strike line 3 and insert the following:

title).

Subtitle G—Modernizing America's Health Care System

PART I—IMPROVING QUALITY AND VALUE THROUGH DELIVERY SYSTEM REFORM

SEC. 3601. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) IN GENERAL.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

''(4) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

''(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) CONFORMING AMENDMENT.—Section 1890(b)(7)(B)(i)(I) of the Social Security Act, as added by section 3014, is amended by inserting ''1886(s)(4)(D),'' after ''1886(o)(2),''.

SEC. 3602. PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the provider.

(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot programs under this section.

(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(B) improve the quality of care and reduce spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII for Medicare beneficiaries.

SEC. 3603. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

Section 3006 of this Act is amended by adding at the end the following new subsection:

''(f) AMBULATORY SURGICAL CENTERS.—

''(1) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 13951(i))).

''(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

''(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

''(B) The reporting, collection, and validation of quality data.

''(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

''(D) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

''(E) Any other issues determined appropriate by the Secretary.

''(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

''(A) consult with relevant affected parties; and

''(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

''(4) REPORT TO CONGRESS.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).''.

SEC. 3604. REVISIONS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in paragraph (a)(2)(B), in the matter preceding clause (i), by striking ''8 conditions'' and inserting ''10 conditions'';

(2) by striking subsection (c)(1)(B) and inserting the following:

''(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

''(i) the Secretary determines that such expansion is expected to—

''(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

''(II) improve the quality of care and reduce spending;

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

''(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.''; and

(3) by striking subsection (g).

SEC. 3605. IMPROVEMENTS TO THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899 of the Social Security Act, as added by section 3022, is amended by adding at the end the following new subsections:

''(i) OPTION TO USE OTHER PAYMENT MODELS.—

''(1) IN GENERAL.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

''(2) PARTIAL CAPITATION MODEL.—

''(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

''(3) OTHER PAYMENT MODELS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

''(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

''(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

''(k) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—During the period beginning on the date of the enactment of this section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.''.

SEC. 3606. INCENTIVES TO IMPLEMENT ACTIVITIES TO REDUCE DISPARITIES.

Section 1311(g)(1) of this Act is amended—

(1) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.''.

SEC. 3607. NATIONAL DIABETES PREVENTION PROGRAM.

Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 5405, is amended by adding at the end the following:

''SEC. 399V-2. NATIONAL DIABETES PREVENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the 'program') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

''(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

''(1) a grant program for community-based diabetes prevention program model sites;

''(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

''(3) a training and outreach program for lifestyle intervention instructors; and

''(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

''(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 3608. SELECTION OF EFFICIENCY MEASURES.

Sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014, are amended by striking ''quality'' each place it appears and inserting ''quality and efficiency''.

SEC. 3609. REGIONAL TESTING OF PAYMENT AND SERVICE DELIVERY MODELS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A(a) of the Social Security Act, as added by section 3021, is amended by inserting at the end the following new paragraph:

''(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.''.

SEC. 3610. ADDITIONAL IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A(a) of the Social Security Act, as added by section 3021, is amended—

(1) in subsection (b)(2)—

(A) in subparagraph (A)—

(i) in the second sentence, by striking ''the preceding sentence may include'' and inserting ''this subparagraph may include, but are not limited to,''; and

(ii) by inserting after the first sentence the following new sentence: ''The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.''; and

(B) in subparagraph (C), by adding at the end the following new clause:

''(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.'';

(2) in subsection (b)(4), by adding at the end the following new subparagraph:

''(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).''; and

(3) in subsection (c)—

(A) in paragraph (1)(B), by striking ''care and reduce spending; and'' and inserting ''patient care without increasing spending;'';

(B) in paragraph (2), by striking ''reduce program spending under applicable titles.'' and inserting ''reduce (or would not result in any increase in) net program spending under applicable titles; and''; and

(C) by adding at the end the following:

''(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.''.

SEC. 3611. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) IN GENERAL.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

''(7) ADDITIONAL INCENTIVE PAYMENT.—

''(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

''(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

''(i) The eligible professional shall—

''(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

''(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

''(aa) the criteria for a registry (as described in subsection (k)(4)); or

''(bb) an alternative form and manner determined appropriate by the Secretary.

''(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

''(I) participates in such a Maintenance of Certification program for a year; and

''(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

''(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

''(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

''(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

''(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) The term 'Maintenance of Certification Program' means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

''(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

''(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

''(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

''(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

''(ii) The term 'qualified Maintenance of Certification Program practice assessment' means an assessment of a physician's practice that—

''(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

''(II) includes a survey of patient experience with care; and

''(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.''.

(b) AUTHORITY.—Section 3002(c) of this Act is amended by adding at the end the following new paragraph:

''(3) AUTHORITY.—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).''.

(c) ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.—

(1) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(2) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 3612. 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.

SEC. 3613. EVALUATION OF TELEHEALTH UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A(b)(2)(B) of the Social Security Act, as added by section 3021, is amended by adding at the end the following new clause:

''(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

''(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

''(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.''.

SEC. 3614. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) IN GENERAL.—Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272), as added by section 3123(a) of this Act, is amended to read as follows:

''(g) FIVE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the '5-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

''(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

''(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

''(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

''(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

''(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

''(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

''(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.''.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272), as amended by section 3123(b) of this Act, is amended by striking ''1-year extension'' and inserting ''5-year extension''.

PART II—PROMOTING TRANSPARENCY AND COMPETITION

SEC. 3621. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value. Such methodology shall take into consideration, where applicable—

(1) the overall cost to enrollees under the plan;

(2) the quality of the care provided for under the plan;

(3) the efficiency of the plan in providing care;

(4) the relative risk of the plan's enrollees as compared to other plans;

(5) the actuarial value or other comparative measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 3622. DATA COLLECTION; PUBLIC REPORTING.

Section 399II(a) of the Public Health Service Act, as added by section 3015, is amended to read as follows:

''(a) IN GENERAL.—

''(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish and implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399JJ. Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

''(2) COLLECTION AND AGGREGATION OF DATA.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

''(3) SCOPE.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (1) involve an increasingly broad range of patient populations, providers, and geographic areas over time.''.

SEC. 3623. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan (and detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'').

(b) CONSIDERATIONS.—In developing the plan, the Secretary shall consider how such modernized computer system could—

(1) in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, make available data in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of CMS programs; and

(2) support consistent evaluations of payment and delivery system reforms under CMS programs.

(c) POSTING OF PLAN.—By not later than 9 months after the date of the enactment of this Act, the Secretary shall post on the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 3624. EXPANSION OF THE SCOPE OF THE INDEPENDENT MEDICARE ADVISORY BOARD.

(a) ANNUAL PUBLIC REPORT.—

(1) REPORT.—Section 1899A of the Social Security Act, as added by section 3403, is amended by adding at the end the following new subsection:

''(n) ANNUAL PUBLIC REPORT.—

''(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

''(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

''(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

''(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

''(C) Epidemiological shifts and demographic changes.

''(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

''(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.''.

(2) ALIGNMENT WITH MEDICARE PROPOSALS.—Section 1899A(c)(2)(B) of the Social Security Act, as added by section 3403, is amended—

(A) in clause (v), by striking ''and'' at the end;

(B) in clause (vi), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.''.

(b) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—Section 1899A of the Social Security Act, as added by section 3403 and as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

''(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

''(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

''(A) that the Secretary or other Federal agencies can implement administratively;

''(B) that may require legislation to be enacted by Congress in order to be implemented;

''(C) that may require legislation to be enacted by State or local governments in order to be implemented;

''(D) that private sector entities can voluntarily implement; and

''(E) with respect to other areas determined appropriate by the Board.

''(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

''(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.''.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsections (a)(1) and (b).

SEC. 3625. ADDITIONAL PRIORITY FOR THE NATIONAL HEALTH CARE WORKFORCE COMMISSION.

Section 5101(d)(4)(A) of this Act is amended by adding at the end the following new clause:

''(v) An analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.''.

PART III—PROMOTING ACCOUNTABILITY AND RESPONSIBILITY

SEC. 3631. HEALTH CARE FRAUD ENFORCEMENT.

(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term ''Federal health care offense'' has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(2) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subsection, the United States Sentencing Commission shall—

(A) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(B) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(C) amend the Federal Sentencing Guidelines to provide—

(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000; and

(iv) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(3) REQUIREMENTS.—In carrying this subsection, the United States Sentencing Commission shall—

(A) ensure that the Federal Sentencing Guidelines and policy statements—

(i) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(ii) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(B) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in paragraph (2);

(C) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(D) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(E) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(F) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting ''(a)'' before ''Whoever knowingly''; and

(2) by adding at the end the following:

''(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(c) HEALTH CARE FRAUD OFFENSE.—Section 24(a) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semicolon and inserting ''or section 1128B of the Social Security Act (42 U.S.C. 1320a–7b); or''; and

(2) in paragraph (2)—

(A) by inserting ''1349,'' after ''1343,''; and

(B) by inserting ''section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),'' after ''title,''.

(d) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(1) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking ''to the grand jury''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''grand jury subpoena'' and inserting ''subpoena for records''; and

(ii) in the matter following subparagraph (B), by striking ''to the grand jury''.

(2) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

''SEC. 3A. SUBPOENA AUTHORITY.

''(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

''(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

''(1) ISSUANCE.—Subpoenas issued under this section—

''(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

''(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

''(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

''(c) PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

''(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

''(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

''(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.''.

SEC. 3632. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

(1) DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—Section 1173(a) of the Social Security Act (42 U.S.C. 1320d–2(a)), as amended by section 1104(b)(2), is amended—

(A) in paragraph (1)(B), by inserting before the period the following: '', and subject to the requirements under paragraph (5)''; and

(B) by adding at the end the following new paragraph:

''(5) CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.—

''(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

''(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

''(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

''(B) SOLICITATION OF INPUT.—For purposes of subparagraph (A), the Secretary shall seek input from—

''(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

''(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.''.

(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.—For purposes of section 1173(a)(5) of the Social Security Act, as added by subsection (a), the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker's compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))).

(5) Whether health plans should be required to publish their timeliness of payment rules.

(c) ICD CODING CROSSWALKS.—

(1) ICD-9 TO ICD-10 CROSSWALK.—The Secretary shall task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9 and ICD-10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

(2) REVISION OF CROSSWALK.—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

(3) USE OF REVISED CROSSWALK.—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

(4) SUBSEQUENT CROSSWALKS.—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

SA 3120. Mr. CRAPO 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 1997, strike line 1 and all that follows through page 1998, line 12.

SA 3121. Mr. CRAPO 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 2045, strike line 1 and all that follows through page 2046, line 24.

SA 3122. Mr. CRAPO 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 3123. Mr. CRAPO 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 2034, strike line 16 and all that follows through page 2035, line 15.

SA 3124. Mr. CRAPO 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 2040, strike line 18 and all that follows through page 2044, line 7.

SA 3125. Mr. CRAPO 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 3126. Mr. CRAPO 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, insert the following:

SEC. 9024. EXEMPTION FROM TAXES, FEES, AND PENALTIES.

(a) IN GENERAL.—No tax, fee, or penalty imposed by this Act shall apply to any taxpayer for any taxable year if, as determined by the Secretary of the Treasury, such tax, fee, or penalty would increase the rate of tax imposed on such taxpayer under any provision of the Internal Revenue Code of 1986 or any other applicable Federal law in effect on the day before the date of the enactment of this Act, as compared to the rate of tax imposed on such taxpayer under such provision of law on December 31, 1999.

(b) NEW TAXPAYERS.—In the case of a taxpayer that was not in existence on December 31, 1999, or that had no Federal tax liability on such date, subsection (a) shall be applied by substituting ''December 31 of the first calendar year after 1999 in which such taxpayer had Federal tax liability greater than zero'' for ''December 31, 1999''.

SA 3127. Mr. MERKLEY (for himself and Mrs. MURRAY) 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 1382, between lines 10 and 11, insert the following:

(c) ADVANCED TECHNOLOGY EDUCATION PROGRAM FOR NURSING.—Title VIII of the Public Health Service Act is amended by inserting after section 831A (42 U.S.C. 296b), as added by subsection (b), the following:

''SEC. 831B. ADVANCED TECHNOLOGY EDUCATION PROGRAM FOR NURSING.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a grant program to assist consortia in advancing nursing education and the career ladder.

''(b) PROGRAM DESIGN.—The grant program established under subsection (a) shall—

''(1) be designed to strengthen and expand the nursing career ladder, particularly with regard to innovative programs that encourage registered nurses to pursue advanced degrees in nursing, with an emphasis on integrating innovative technology into nursing education programs; and

''(2) place emphasis on the needs of nontraditional students and underserved groups.

''(c) APPLICATIONS.—An application for a grant under subsection (a) shall be submitted—

''(1) by a two-year educational institution on behalf of the consortia seeking the grant; and

''(2) at such time, in such manner, and containing such information as the Secretary may require.

''(d) ADVANCED TECHNOLOGY EDUCATION PROJECTS IN NURSING.—Funds made available

through a grant under subsection (a) shall be used to support nursing education projects, to enhance nursing education programs, and to assist students in transferring academic credit from a two-year educational institution to an advanced degree program in nursing through activities such as—

''(1) alignment and enhancement of curriculum to ensure that academic credit earned at a two-year educational institutions can be transferred to baccalaureate or graduate degree programs in nursing;

''(2) establishment of innovative partnerships and articulation agreements to facilitate the transfer by students of academic credit from a two-year educational institution to an advanced degree program in nursing;

''(3) the purchase or lease of state-of-the-art technologies essential in developing innovative nursing education programs and in preparing nursing students to use current and future health technologies, such as simulation and visualization tools and telehealth;

''(4) the acquisition of technical support necessary for developing innovative nursing curriculum and advanced technology training capabilities among nursing faculty;

''(5) professional development and training of nursing faculty, both full- and part-time, in the nursing profession;

''(6) development and dissemination of exemplary curricula and instructional materials in nursing;

''(7) development and implementation of innovative workshops, mentoring activities, and professional development activities for nursing students, registered nurses, and nursing faculty to encourage education advancement and retention in a nursing career; and

''(8) development and implementing internship programs for nurses or nursing students to encourage mentoring.

''(e) DEFINITION.—In this section—

''(1) the term 'consortia' means a collaboration that—

''(A) shall include a two-year educational institution in partnership with a four-year college or university; and

''(B) may include one or more of the following: another two-year or four-year college or university, a school of nursing, the private sector, a State or local government, a State workforce investment board, a local workforce investment board, a community-based allied health program, a health professions school, a teaching hospital, a graduate medical education program, an academic health center, and any other appropriate public or private non-profit entity;

in order to inform and improve nursing education programs;

''(2) the term 'four-year educational institution' means a department, division, or other administrative unit in a college or university which provides primarily or exclusively an accredited program in professional nursing and related subjects leading to the degree of bachelor of arts, bachelor of science, bachelor of nursing, or to an equivalent degree, or to a graduate degree in nursing, or to an equivalent degree, and including advanced training related to such program of education provided by such school;

''(3) the term 'local workforce investment board' refers to a local workforce investment board established under section 117 of the Workforce Investment Act of 1998 (29 U.S.C. 2832);

''(4) the term 'State workforce investment board' refers to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821); and

''(5) the term 'two-year educational institution' means a department, division, or other administrative unit in a junior or community college which provides primarily or exclusively a two-year accredited nursing program leading to an associate degree in nursing or an equivalent degree, but only if such program, or such unit or college, is accredited.

''(f) FUNDING.—There are authorized to be appropriated to award grants under this section, $12,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SA 3128. Mr. KOHL 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 921, between lines 20 and 21, insert the following:

SEC. 3210. EXPANSION OF 340B PROGRAM COVERED ENTITIES AND RECEIPT BY CERTAIN PACE PROGRAMS AND SNPS OF PERCENTAGE OF SAVINGS FROM PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF 340B PROGRAM COVERED ENTITIES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), as amended by section 7101, is further amended by adding at the end the following:

''(P) An entity that is—

''(i) a PACE program under section 1894 of the Social Security Act; or

''(ii) a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act, all or nearly all of whom are nursing home certifiable, that is fully integrated with capitated contracts with States for Medicaid benefits.''.

(b) RECEIPT BY CERTAIN PACE PROGRAMS AND SNPS OF PERCENTAGE OF SAVINGS FROM PARTICIPATION IN 340B PROGRAM.—

(1) PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee), as amended by section 3201(i), is further amended—

(A) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively; and

(B) by inserting after subsection (h) the following new subsection:

''(i) RECEIPT BY CERTAIN PACE PROGRAMS OF PERCENTAGE OF SAVINGS FROM PARTICIPATION IN 340B PROGRAM.—

''(1) IN GENERAL.—An applicable PACE program is eligible to receive from the Secretary an amount equal to 10 percent of the estimated savings to the program under this title as a result of participation in the program under section 340B of the Public Health Service Act (as determined by the Secretary).

''(2) APPLICABLE PACE PROGRAM DEFINED.—For purposes of paragraph (1), the term 'applicable PACE program' means a PACE program that—

''(A) is participating in the program under section 340B of the Public Health Service Act;

''(B) submits to the Secretary an application in such form and manner, and containing such information, as the Secretary may specify; and

''(C) has in effect a plan approved by the Secretary for the use of any amounts received by the program or plan under paragraph (1) to provide enhanced formulary coverage, medication management, or disease management to enrollees.''.

(2) SNPS.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28), as amended by section 3208, is further amended by adding at the end the following new subsection:

''(h) RECEIPT BY CERTAIN SNPS OF PERCENTAGE OF SAVINGS FROM PARTICIPATION IN 340B PROGRAM.—

''(1) IN GENERAL.—An applicable specialized MA plan for specialized needs individuals is eligible to receive from the Secretary an amount equal to 10 percent of the estimated savings to the program under this title as a result of participation in the program under section 340B of the Public Health Service Act (as determined by the Secretary).

''(2) APPLICABLE SPECIALIZED MA PLAN FOR SPECIAL NEEDS INDIVIDUALS DEFINED.—For purposes of paragraph (1), the term 'applicable specialized MA plan for special needs individuals' means a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), all or nearly all of whom are nursing home certifiable, that is fully integrated with capitated contracts with States for Medicaid benefits that—

''(A) is participating in the program under section 340B of the Public Health Service Act;

''(B) submits to the Secretary an application in such form and manner, and containing such information, as the Secretary may specify; and

''(C) has in effect a plan approved by the Secretary for the use of any amounts received by the program or plan under paragraph (1) to provide enhanced formulary coverage, medication management, or disease management to enrollees.''.

(c) DEVELOPMENT OF NEW PROGRAM.—The Secretary of Health and Human Services may develop and implement a program whereby such Secretary enters into an agreement with manufacturers that participate in the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) under which enrollees in PACE programs under section 1894 of the Social Security Act (42 U.S.C. 1395eee) and specialized MA plans for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w–28) may receive covered drugs (as defined under such section 340B) from pharmacies selected by the PACE program or specialized MA plan, including local pharmacies.

SA 3129. Mrs. MURRAY 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 1411, between lines 5 and 6, insert the following:

SEC. 5316. SECONDARY SCHOOL HEALTH SCIENCES TRAINING PROGRAM.

(a) PROGRAM AUTHORIZED.—

(1) IN GENERAL.—The Secretary is authorized to establish a health sciences training program consisting of awarding grants, on a competitive basis, to eligible recipients to enable the eligible recipients to prepare secondary school students for careers in health professions.

(2) CONSULTATION AND COLLABORATION.—The Secretary of Education shall—

(A) consult with the Secretary of Health and Human Services and the Secretary of Labor prior to the issuance of a solicitation for grant applications under this section; and

(B) specifically collaborate with the Secretary of Health and Human Services to coordinate the program under this section with any programs administered by the Health Resources and Services Administration that create a pipeline of professionals for the health care workforce.

(b) DEVELOPMENT AND IMPLEMENTATION OF HEALTH SCIENCES PROGRAMS OF STUDY.—An eligible recipient receiving a grant under this section shall use grant funds—

(1) to implement a secondary school health sciences program of study that—

(A) meets the requirements for a career and technical program of study under section 122(c)(1)(A) of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2342(c)(1)(A));

(B) is aligned with—

(i) the career and technical programs of study supported by the State in which the eligible recipient is located, in accordance with the State's plan under section 122(c) of such Act (20 U.S.C. 2342(c)); and

(ii) any technical standards required for State licensure in a health profession; and

(C) prepares students for—

(i) a postsecondary certificate, credential, or accredited associate's or baccalaureate degree program in the health profession; or

(ii) an accredited baccalaureate degree program in an academic major related to the health profession; and

(2) to increase the interest of secondary school students in applying to, and enrolling in, programs described in clause (i) or (ii) of paragraph (1)(C), including through—

(A) work-study programs;

(B) pre-apprenticeship programs;

(C) programs to increase awareness of careers in health professions; or

(D) other activities to increase such interest.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an eligible recipient shall—

(1) provide assurances that activities under the grant will be carried out in partnership with—

(A) an accredited health professions school or program at the postsecondary level; and

(B) a public or private nonprofit hospital or public or private nonprofit entity with a focus on health sciences or health professions; and

(2) provide an explanation of how activities under the grant are consistent with the State plan and local plan being implemented under sections 122 and 134, respectively, of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2342, 2354), for the area to be served by the grant.

(d) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to an eligible recipient that has a demonstrated record of not less than one of the following:

(1) Graduating, or collaborating with an eligible recipient that graduates, a high or significantly improved percentage of students who have exhibited mastery in secondary school State science standards.

(2) Graduating students from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented in—

(A) the programs described in clause (i) or (ii) of subsection (b)(1)(C); or

(B) the health professions.

(e) REPORT.—The Secretary shall submit to Congress an annual report on the program carried out under this section.

(f) DEFINITIONS.—In this section:

(1) ELIGIBLE RECIPIENT.—The term ''eligible recipient'' means an eligible recipient described in section 3(14)(A) of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2302(14)(A)).

(2) HEALTH CARE WORKFORCE.—The term ''health care workforce'' has the meaning given the term in section 5101(i).

(3) HEALTH PROFESSION.—The term ''health profession'' means the profession of a member of the health care workforce.

(4) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(5) SECONDARY SCHOOL.—The term ''secondary school''—

(A) means a secondary school, as defined in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801); and

(B) includes a middle school.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Education, except as otherwise specified.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2011 through 2015.

SA 3130. Mr. JOHANNS 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 245, between lines 14 and 15, and insert the following:

(B) SPECIAL RULE FOR LOW-INCOME ADULTS NOT ELIGIBLE FOR MEDICAID.—If a taxpayer is an individual who, but for the application of section 1902(k)(2) of the Social Security Act, a State would be required under subclause (VIII) of subsection (a)(10)(A)(i) to provide medical assistance to under the State Medicaid plan, the taxpayer shall—

(i) for purposes of the credit under this section, be treated as an applicable taxpayer and the applicable percentage with respect to such taxpayer shall be 2.0 percent; and

(ii) for purposes of reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, shall be treated as having household income of more than 100 percent but less than 150 percent of the poverty line (as so defined) applicable to a family of the size involved.

On page 398, between lines 9 and 10, insert the following:

(B) SPECIAL RULES FOR STATES WITH A BUDGET DEFICIT OR AT RISK OF HAVING TO RAISE TAXES OR BEING UNABLE TO DELIVER ESSENTIAL STATE FUNCTIONS.—Section 1902(k) of such Act (42 U.S.C. 1396a(k)), as added by subparagraph (A), is amended by adding at the end the following:

''(2) If a State submits a certification to the Secretary in 2013 that in 2014, complying with the requirement under subclause (VIII) of subsection (a)(10)(A)(i) to provide medical assistance to individuals described in that subclause would cause the State to have a budget deficit, or require the State to raise taxes, or reduce or eliminate spending for education, transportation, law enforcement or other essential State functions, then, in the case of individuals described in the subclause who have attained 19 years of age, the State only shall be required to provide medical assistance under that subclause to those individuals with income (as determined under subsection (e)(14)) that does not exceed 75 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.''.

SA 3131. Mr. KOHL (for himself 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, 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 ____—PROHIBITION ON DATA MINING

SEC. __01. PURPOSE.

(a) IN GENERAL.—It is the purpose of this title to—

(1) safeguard the confidentiality of prescribing information;

(2) protect the integrity of the doctor-patient relationship;

(3) maintain the integrity and public trust in the medical profession;

(4) combat vexatious and harassing sales practices;

(5) restrain undue influence exerted by pharmaceutical industry marketing representatives over prescribing decisions; and

(6) improve the quality and lower the cost of health care.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to regulate the monitoring of prescribing practices for uses other than marketing (such as quality control, research unrelated to marketing, or use by governments or other entities not in the business of selling health care products).

SEC. __02. DEFINITIONS.

In this title:

(1) BONA FIDE CLINICAL TRIAL.—The term ''bona fide clinical trial'' means any research project that—

(A) prospectively assigns human subjects to intervention and comparison groups to study the cause and effect relationship between a medical intervention and a health outcome;

(B) has received approval from an appropriate Institutional Review Board; and

(C) has been registered at ClinicalTrials.Gov prior to commencement.

(2) COMPANY MAKING OR SELLING PRESCRIBED PRODUCTS.—The term ''company making or selling prescribed products'' means a pharmacy, a pharmacy benefit manager, a pharmaceutical manufacturer, pharmaceutical wholesaler, or any other entity whose primary purpose is the marketing of pharmaceutical product for financial gain. Such term does not include health plans, health care providers, or State or Federal public health programs and research organizations.

(3) INDIVIDUAL IDENTIFYING INFORMATION.—The term ''individual identifying information'' means information that directly or indirectly identifies a prescriber or a patient, where the information is derived from or relates to a prescription for any prescribed product.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

(5) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(2))). Such term includes the following (singly or in combination):

(i) A group health plan, as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

(ii) A health insurance issuer, as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

(iii) A health maintenance organization, as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

(iv) Part A or part B of the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.

(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1))).

(vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.

(viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.

(ix) The health care program for active military personnel under title 10, United States Code.

(x) The veterans health care program under chapter 17 of title 38, United States Code.

(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in section 1072(4) of title 10, United States Code).

(xii) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq).

(xiii) The Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(xiv) An approved State child health plan under title XXI of the Social Security Act, providing benefits for child health assistance that meet the requirements of section 2103 of such Act (42 U.S.C. 1397, et seq).

(xv) The Medicare+Choice program under Part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

(xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(2))).

(B) LIMITATION.—Such terms shall not include the following:

(i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(1)).

(ii) A government-funded program (other than a program listed in clauses (i) through (xvi) of subparagraph (A)—

(I) whose principal purpose is other than providing, or paying the cost of, health care; or

(II) whose principal activity is—

(aa) the direct provision of health care to persons; or

(bb) the making of grants to fund the direct provision of health care to persons.

(6) MARKETING.—The term ''marketing'' means any activity advertising, promoting, or selling a prescribed product for commercial gain, including—

(A) identifying individuals to receive a message promoting use of a particular product;

(B) identifying individuals to receive any form of gift, product sample, consultancy, or any other item, service, compensation or employment of value;

(C) planning the substance of a sales representative visit or communication or the substance of an advertisement or other promotional message or document; or

(D) evaluating or compensating sales representatives.

(7) PERSON.—The term ''person'' means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

(8) PHARMACY.—The term ''pharmacy'' means any person licensed under State or Federal law to dispense prescribed products.

(9) PRESCRIBED PRODUCT.—The term ''prescribed product'' includes a biological product as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) and a device or a drug as defined in section 201 of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321).

(10) REGULATED RECORD.—The term ''regulated record'' means information or documentation from a prescription.

SEC. __03. PRIVACY PROTECTIONS.

(a) PROHIBITION.—No company or person in possession of regulated records, or their agents, or those acting on their behalf shall knowingly disclose, sell, or use regulated records containing individual identifying information for marketing a prescribed product.

(b) PERMITTED TRANSFERS.—A regulated record containing individual identifying information may be transferred to another entity, including to another branch or subsidiary of the same entity, only if the transfer provides satisfactory assurance that the recipient will safeguard the records from being disclosed or used for a marketing purpose prohibited under this section.

(c) PERMITTED USES.—

(1) IN GENERAL.—Regulated records containing individual identifying information may be disclosed, sold, transferred, exchanged, or used for any purpose other than marketing a prescribed product, including—

(A) to fill a valid prescription, including communication by a pharmacist about patient safety or generic substitution, or in response to patient or physician questions about a medication, as well as any transfer necessary for billing or pharmacy reimbursement;

(B) to conduct of a bona fide clinical trial;

(C) to disseminate safety warnings, labeling changes, risk evaluation and mitigation strategies (REMS) compliance communications, or to facilitate adverse event reporting, or to otherwise implement a REMS;

(D) for the purposes of academic detailing or public health communications;

(E) for the administration of a patient's health insurance or benefits plan, including determining compliance with the terms of coverage or medical necessity; or

(F) to comply with existing State or Federal law.

(2) RULES OF CONSTRUCTION.—This section shall not be construed to—

(A) prohibit any communication between a health care provider and patients under his or her care, or any communication between health care providers for the purpose of patient care;

(B) prohibit the use of data by a health plan or a pharmacy benefit manager where such plan or manager is acting in the fiduciary interest of such organizations, for purposes of planning, conducting, or evaluating formulary compliance or quality assurance program based on evidence based prescribing or cost-containment goals;

(C) prohibit conduct that involves the collection, use, transfer, or sale of regulated records for marketing purposes if—

(i) the data involved does not contain individually identifying information; and

(ii) there is no reasonable basis to believe that the data can be used to obtain individually identifying information; and

(D) prevent any person from disclosing regulated records to the identified individual as long as the information does not include protected information pertaining to any other person.

(d) REGULATIONS.—The Attorney General may promulgate regulations as necessary to implement this title.

(e) ENFORCEMENT.—Any person who knowingly fails to comply with the requirements of this title, or regulations promulgated pursuant to this title, by using or disclosing regulated records in a manner not authorized by this title, or regulations, shall be subject to an civil penalty of at least $10,000, and not more than $50,000, per violation, as assessed by the Attorney General. Each disclosure of a regulated record shall constitute a violation of this title. The Attorney General shall take necessary action to enforce the payment of penalties assessed under this section.

SEC. __04. SEVERABILITY.

If any provision of this title, or its application to any person or circumstance, is held invalid, the remainder of this title, or the application of the provision, to other persons or circumstances shall not be affected.

SEC. __05. NO EFFECT ON TRUTHFUL SPEECH TO DOCTORS OR PATIENTS.

Nothing in this title shall be construed to regulate the content, time, place, or manner of any discussion between a prescriber and their patient, or a prescriber and any person representing a prescription drug manufacturer.

SA 3132. Mrs. MCCASKILL 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 40, between lines 21 and 22, insert the following:

SEC. 1003A. STUDY TO PROVIDE HEALTH CARE INFLATION TRANSPARENCY AND ACCOUNTABILITY.

(a) FINDINGS.—Congress finds the following:

(1) Manufacturers of drugs have increased wholesale prices of brand-name drugs by approximately 9 percent in the period from 2008 to 2009, while all other sectors of the economy experienced a 1.3 percent decline in such period.

(2) Insurance brokers and benefits consultants predict that the small business clients of such brokers and consultants will experience an increase in premiums by an average of approximately 15 percent for 2010, which is double the rate of such increase that occurred for 2009.

(b) DEFINITIONS.—In this section:

(1) HEALTH CARE SECTOR.—The term ''health care sector'' includes manufacturers of drugs, manufacturers of devices, hospitals, insurance companies, laboratories, and health care providers that are affected by this Act (and the amendments made by this Act).

(2) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' means those health insurance issuers subject to section 2794(a) of the Public Health Service Act (as added by section 1003)

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) ANNUAL STUDY.—

(1) IN GENERAL.—The Secretary, in coordination with the Attorney General and the Chairman of the Federal Trade Commission, shall, on an annual basis, collect and study data on pricing in the health care sector. Such data shall include the information provided to the Secretary under section 2794(b)(1)(A) of the Public Health Service Act (as added by section 1003).

(2) INITIAL STUDY.—The initial such study shall be for the 1-year period beginning on July 1, 2009, and ending on the date of the first report under subsection (e).

(3) SUBSEQUENT STUDIES.—Each subsequent study shall be for the 1-year period following the date of the preceding report under subsection (e).

(d) COLLECTION OF DATA.—Health insurance issuers and entities operating within the health care sector shall provide to the Secretary information on price, demographics, and any other variable or factor the Secretary may deem necessary to determine if premiums, retail or wholesale prices, or other costs are being increased unreasonably, including information about the actuarial value of the plans of the issuer and the medical loss ratio of such plans.

(e) REPORTS.—

(1) IN GENERAL.—Based on the annual study conducted under subsection (c), the Secretary, in coordination with the Attorney General and the Chairman of the Federal Trade Commission, shall publish an annual report on the excess price inflation in the health care sector that occurred during the period described in such subsection.

(2) EXCESS PRICE INFLATION.—For purposes of the report, the term ''excess price inflation'' shall be defined by the Secretary, in consultation with the Attorney General, the Director of the Congressional Budget Office, and other Government experts and economists as the Secretary determines appropriate.

(f) EFFECT OF STUDY AND REPORTS.—

(1) REIMBURSEMENT RATES.—The results of the study and report under this section shall be taken into account—

(A) when reimbursement rates for Federal health programs are established for the years following such report; and

(B) by States, when making recommendations under section 2974(b)(1)(B) of the Public Health Service Act (as added by section 1003).

(2) REBATES.—

(A) HEALTH INSURANCE ISSUERS.—Based on a study conducted under subsection (c), if insurance premiums of a health insurance issuer are determined by the Secretary, in coordination with the Attorney General and the Chairman of the Federal Trade Commission, to meet the definition of excess price inflation, such issuer shall provide to each enrollee of such issuer a rebate. The amount of the rebate shall be calculated using the formula described under section 2718(b) of the Public Health Service Act (as added by section 1001), except for the amount of the excess price inflation shall be substituted for the amount of the premium revenues.

(B) HEALTH CARE SECTOR ENTITIES.—Based on a study conducted under subsection (c), if the Secretary determines, in coordination with the Attorney General and the Chairman of the Federal Trade Commission, that an entity within the health care sector has increased price of goods or services related to such entity's participation in the health care sector, such as drugs or devices, sufficient to meet the definition of excess price inflation, then such entity shall pay to the Treasury the amount of the excess price inflation for the purpose of deficit reduction.

(3) APPEAL OF DETERMINATION.—The Secretary shall establish an effective appeals process under which a health insurance issuer or health care entity within the health care sector may appeal the determination of excess price inflation described in paragraph (2). In making an appeals determination, the Secretary may consult with the Attorney General, the Chairman of the Federal Trade Commission, the Director of the Congressional Budget Office, and other Government experts and economists as the Secretary determines appropriate.

(g) PUBLIC AVAILABILITY.—The Secretary shall make each report under subsection (e), and the supporting data describing excess price inflation in the health care sector, available to the public.

SA 3133. Mr. WICKER 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:

TITLE X—ADDITIONAL PROVISIONS

Subtitle A—Physician Payment Update Commission

SEC. 10001. SHORT TITLE.

This subtitle may be cited as the ''Physician Payment Update Commission Act''.

SEC. 10002. ESTABLISHMENT OF PHYSICIAN PAYMENT UPDATE COMMISSION.

(a) MEDICARE PHYSICIAN FEE SCHEDULE UPDATE AND SUNSET OF MEDICARE SUSTAINABLE GROWTH RATE FORMULA.—

(1) UPDATE FOR 2010 AND 2011.—Section 1848(d)(10) of the Social Security Act (42 U.S.C. 1395w–4(d)(10)), as added by section 3101, is amended to read as follows:

''(10) UPDATE FOR 2010 AND 2011.—

''(A) IN GENERAL.—The update to the single conversion factor established in paragraph (1)(C) for 2010 and 2011 shall be 0 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2012 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.''.

(2) SUNSET OF MEDICARE SUSTAINABLE GROWTH RATE FORMULA.—Effective January 1, 2012, subsection (f) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is repealed.

(b) ESTABLISHMENT OF PHYSICIAN PAYMENT UPDATE COMMISSION.—

(1) IN GENERAL.—There is established a commission to be known as the ''Physician Payment Update Commission'' (referred to in this section as the ''Commission'').

(2) MEMBERSHIP.—

(A) COMPOSITION.—The Commission shall be composed of 17 members appointed by the Comptroller General of the United States, upon the recommendation of the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) DATE OF APPOINTMENTS.—Members of the Commission shall be appointed not later than 2 months after the date of enactment of this Act.

(3) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, integrated delivery systems, allopathic and osteopathic medicine and other areas of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) INCLUSION.—The members of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(C) MAJORITY PHYSICIANS AND OTHER HEALTH PROFESSIONALS.—Individuals who are physicians or other health professionals shall constitute a majority of the membership of the Commission.

(4) TERM; VACANCIES.—

(A) TERM.—A member shall be appointed for the life of the Commission.

(B) VACANCIES.—A vacancy on the Commission—

(i) shall not affect the powers of the Commission; and

(ii) shall be filled in the same manner as the original appointment was made.

(5) MEETINGS.—The Commission shall meet at the call of the Chairperson.

(6) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON.—The Comptroller General shall designate a member of the Commission, at the time of the appointment of the member, as Chairperson.

(c) DUTIES.—

(1) STUDY.—The Commission shall conduct a study of all matters relating to payment rates under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) RECOMMENDATIONS.—The Commission shall develop recommendations on the establishment of a new physician payment system under the Medicare program that would appropriately reimburse physicians by keeping pace with increases in medical practice costs and providing stable, positive Medicare updates.

(3) REPORT.—Not later than December 1, 2010, the Commission shall submit to the appropriate Committees of Congress and the Medicare Payment Advisory Commission—

(A) a detailed statement of the findings and conclusions of the Commission;

(B) the recommendations of the Commission for such legislation and administrative actions as the Commission considers appropriate (including proposed legislative language to carry out such recommendations); and

(C) a long-term CBO cost estimate regarding such recommendations (as described under subsection (i)).

(d) POWERS.—

(1) HEARINGS.—The Commission may hold such hearings, meet and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—

(A) IN GENERAL.—The Commission may secure directly from a Federal agency such information as the Commission considers necessary to carry out this section.

(B) PROVISION OF INFORMATION.—On request of the Chairperson of the Commission, the head of the agency shall provide the information to the Commission.

(3) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other agencies of the Federal Government.

(e) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—

(A) IN GENERAL.—Members of the Commission shall serve without compensation in addition to the compensation received for the services of the member as an officer or employee of the Federal Government.

(B) TRAVEL EXPENSES.—A member of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Commission.

(2) STAFF AND SUPPORT SERVICES.—

(A) EXECUTIVE DIRECTOR.—The Chairperson shall appoint an executive director of the Commission.

(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(f) TERMINATION OF COMMISSION.—The Commission shall terminate 30 days after the date on which the Commission submits its report under subsection (c)(3).

(g) REVIEW AND RESPONSE TO RECOMMENDATIONS BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—

(1) IN GENERAL.—Not later than February 1, 2011, the Medicare Payment Advisory Commission shall—

(A) review the recommendations included in the report submitted under subsection (c)(3);

(B) examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities; and

(C) submit to the appropriate Committees of Congress a report on such review.

(2) CONTENTS OF REPORT ON REVIEW OF COMMISSION RECOMMENDATIONS.—The report submitted under paragraph (1)(C) shall include—

(A) if the Medicare Payment Advisory Commission supports the recommendations of the Commission, the reasons for such support; or

(B) if the Medicare Payment Advisory Commission does not support such recommendations, the recommendations of the Medicare Payment Advisory Commission, together with an explanation as to why the Medicare Payment Advisory Commission does not support the recommendations of the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the Commission to carry out this section. Such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(i) LONG-TERM CBO COST ESTIMATE.—

(1) PREPARATION AND SUBMISSION.—When the Commission submits a written request to the Director of the Congressional Budget Office for a long-term CBO cost estimate of recommended legislation or administrative actions (as described under subsection (c)(3)), the Director shall prepare the estimate and have it published in the Congressional Record as expeditiously as possible.

(2) CONTENT.—A long-term CBO cost estimate shall include—

(A) an estimate of the cost of each provision (if practicable) or group of provisions of the recommended legislation or administrative actions for first fiscal year it would take effect and for each of the 49 fiscal years thereafter; and

(B) a statement of any estimated future costs not reflected by the estimate described in subparagraph (A).

(3) FORM.—To the extent that a long-term CBO cost estimate presented in dollars is impracticable, the Director of the Congressional Budget Office may instead present the estimate in terms of percentages of gross domestic product, with rounding to the nearest 1/10 of 1 percent of gross domestic product.

(4) LIMITATIONS ON DISCRETIONARY SPENDING.—A long-term CBO cost estimate shall only consider the effects of provisions affecting revenues and direct spending (as defined by the Balanced Budget and Emergency Deficit Control Act of 1985), and shall not assume that any changes in outlays will result from limitations on, or reductions in, annual appropriations.

(j) EXPEDITED CONSIDERATION OF COMMISSION RECOMMENDATIONS.—

(1) INTRODUCTION.—

(A) IN GENERAL.—The proposed legislative language contained in the report submitted pursuant to subsection (c)(3) (referred to in this subsection as the ''Commission bill'') shall be introduced within the first 10 calendar days of the 112th Congress (or on the first session day thereafter) in the House of Representatives and in the Senate by the majority leader of each House of Congress, for himself, the minority leader of each House of Congress, for himself, or any member of the House designated by the majority leader or minority leader. If the Commission bill is not introduced in accordance with the preceding sentence in either House of Congress, then any Member of that House may introduce the Commission bill on any day thereafter. Upon introduction, the Commission bill shall be referred to the appropriate committees under subparagraph (B).

(B) COMMITTEE CONSIDERATION.—A Commission bill introduced in either House of Congress shall be jointly referred to the committee or committees of jurisdiction, which shall report the bill without any revision and with a favorable recommendation, an unfavorable recommendation, or without recommendation, not later than 10 calendar days after the date of introduction of the bill in that House. If any committee fails to report the bill within that period, that committee shall be automatically discharged from consideration of the bill, and the bill shall be placed on the appropriate calendar.

(2) EXPEDITED PROCEDURE.—

(A) IN THE HOUSE OF REPRESENTATIVES.—

(i) IN GENERAL.—Not later than 5 days of session after the date on which a Commission bill is reported or discharged from all committees to which it was referred, the majority leader of the House of Representatives or the majority leader's designee shall move to proceed to the consideration of the Commission bill. It shall also be in order for any Member of the House of Representatives to move to proceed to the consideration of the Commission bill at any time after the conclusion of such 5-day period.

(ii) MOTION TO PROCEED.—A motion to proceed to the consideration of the Commission bill is highly privileged in the House of Representatives and is not debatable. The motion is not subject to amendment or to a motion to postpone consideration of the Commission bill. A motion to proceed to the consideration of other business shall not be in order. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives shall immediately proceed to consideration of the Commission bill without intervening motion, order, or other business, and the Commission bill shall remain the unfinished business of the House of Representatives until disposed of.

(iii) LIMITS ON DEBATE.—Debate in the House of Representatives on a Commission bill under this paragraph shall not exceed a total of 100 hours, which shall be divided equally between those favoring and those opposing the bill. A motion further to limit debate is in order and shall not be debatable. It shall not be in order to move to recommit a Commission bill under this paragraph or to move to reconsider the vote by which the bill is agreed to or disagreed to.

(iv) APPEALS.—Appeals from decisions of the chair relating to the application of the Rules of the House of Representatives to the procedure relating to a Commission bill shall be decided without debate.

(v) APPLICATION OF HOUSE RULES.—Except to the extent specifically provided in this paragraph, consideration of a Commission bill shall be governed by the Rules of the House of Representatives. It shall not be in order in the House of Representatives to consider any Commission bill introduced pursuant to the provisions of this subsection under a suspension of the rules or under a special rule.

(vi) NO AMENDMENTS.—No amendment to the Commission bill shall be in order in the House of Representatives.

(vii) VOTE ON FINAL PASSAGE.—In the House of Representatives, immediately following the conclusion of consideration of the Commission bill, the vote on final passage of the Commission bill shall occur without any intervening action or motion, requiring an affirmative vote of 3/5 of the Members, duly chosen and sworn. If the Commission bill is passed, the Clerk of the House of Representatives shall cause the bill to be transmitted to the Senate before the close of the next day of session of the House.

(B) IN THE SENATE.—

(i) IN GENERAL.—Not later than 5 days of session after the date on which a Commission bill is reported or discharged from all committees to which it was referred, the majority leader of the Senate or the majority leader's designee shall move to proceed to the consideration of the Commission bill. It shall also be in order for any Member of the Senate to move to proceed to the consideration of the Commission bill at any time after the conclusion of such 5-day period.

(ii) MOTION TO PROCEED.—A motion to proceed to the consideration of the Commission bill is privileged in the Senate and is not debatable. The motion is not subject to amendment or to a motion to postpone consideration of the Commission bill. A motion to proceed to consideration of the Commission bill may be made even though a previous motion to the same effect has been disagreed to. A motion to proceed to the consideration of other business shall not be in order. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the Senate shall immediately proceed to consideration of the Commission bill without intervening motion,

order, or other business, and the Commission bill shall remain the unfinished business of the Senate until disposed of.

(iii) LIMITS ON DEBATE.—In the Senate, consideration of the Commission bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 100 hours, which shall be divided equally between those favoring and those opposing the Commission bill. A motion further to limit debate on the Commission bill is in order and is not debatable. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the Commission bill, including time used for quorum calls and voting, shall be counted against the total 100 hours of consideration.

(iv) NO AMENDMENTS.—No amendment to the Commission bill shall be in order in the Senate.

(v) MOTION TO RECOMMIT.—A motion to recommit a Commission bill shall not be in order under this paragraph.

(vi) VOTE ON FINAL PASSAGE.—In the Senate, immediately following the conclusion of consideration of the Commission bill and a request to establish the presence of a quorum, the vote on final passage of the Commission bill shall occur and shall require an affirmative vote of ⅗ of the Members, duly chosen and sworn.

(vii) OTHER MOTIONS NOT IN ORDER.—A motion to postpone or a motion to proceed to the consideration of other business is not in order in the Senate. A motion to reconsider the vote by which the Commission bill is agreed to or not agreed to is not in order in the Senate.

(viii) CONSIDERATION OF THE HOUSE BILL.—

(I) IN GENERAL.—If the Senate has received the House companion bill to the Commission bill introduced in the Senate prior to the vote required under clause (vi) and the House companion bill is identical to the Commission bill introduced in the Senate, then the Senate shall consider, and the vote under clause (vi) shall occur on, the House companion bill.

(II) PROCEDURE AFTER VOTE ON SENATE BILL.—If the Senate votes, pursuant to clause (vi), on the bill introduced in the Senate, the Senate bill shall be held pending receipt of the House message on the bill. Upon receipt of the House companion bill, if the House bill is identical to the Senate bill, the House bill shall be deemed to be considered, read for the third time, and the vote on passage of the Senate bill shall be considered to be the vote on the bill received from the House.

(C) NO SUSPENSION.—No motion to suspend the application of this paragraph shall be in order in the Senate or in the House of Representatives.

Subtitle B—Medical Care Access Protection

SEC. 10101. SHORT TITLE.

This subtitle may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. 10102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10106. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health

care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10107. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10108. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 10110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 10105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle C—Rescission of Unused Stimulus Funds

SEC. 10201. RESCISSION IN ARRA.

Effective as of October 1, 2010, any unobligated balances available on such date of funds made available by division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) are rescinded.

SA 3134. Mr. BURR (for himself, Mrs. HUTCHISON, and Mr. WICKER) 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 insert the following:

TITLE X—ADDITIONAL PROVISIONS

Subtitle A—Medicare Physician Fee Schedule Update for 2010, 2011, and 2012

SEC. 10001. MEDICARE PHYSICIAN FEE SCHEDULE UPDATE FOR 2010, 2011, AND 2012.

Section 1848(d)(10) of the Social Security Act (42 U.S.C. 1395w–4(d)), as added by section 3101, is amended to read as follows:

''(10) UPDATE FOR 2010, 2011, AND 2012.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for each of 2010, 2011, and 2012, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2013 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.''.

Subtitle B—Medical Care Access Protection

SEC. 10101. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10102. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health

care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10103. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10104. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10105. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10106. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10107. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10108. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 10109. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10110. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 10104(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10111. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle C—Rescission of Discretionary Amounts Appropriated by the American Recovery and Reinvestment Act of 2009

SEC. 10201. RESCISSION OF DISCRETIONARY AMOUNTS APPROPRIATED BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009.

(a) IN GENERAL.—All discretionary amounts made available by the American Recovery and Reinvestment Act of 2009 (123 Stat. 115; Public Law No: 111-5) that are unobligated on the date of the enactment of this Act are hereby rescinded.

(b) ADMINISTRATION.—Not later than 30 days after the date of the enactment of this Act, the Director of the Office of Management and Budget shall—

(1) administer the reduction specified in subsection (a); and

(2) submit to the Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives a report specifying the account and the amount of each reduction made pursuant to subsection (a).

SA 3135. Mr. SANDERS (for himself, Mr. BROWN, Mr. FRANKEN, and Mr. BURRIS) 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 1979, line 20, strike all through page 1996, line 3, and insert the following:

SEC. 9001. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

"SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $4,800,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$2,400,000' for '$4,800,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 3136. Mr. UDALL of New Mexico 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 796, between lines 5 and 6, insert the following:

PART IV—TELEHEALTH AND REMOTE PATIENT MONITORING

SEC. 3031. TELEHEALTH AND REMOTE PATIENT MONITORING.

(a) IMPROVING CREDENTIALING AND PRIVILEGING STANDARDS FOR TELEHEALTH SERVICES.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new paragraph:

''(5) ESTABLISHMENT OF REMOTE CREDENTIALING AND PRIVILEGING STANDARDS.—

''(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, the Secretary shall establish regulations for considering the remote credentialing and privileging standards applicable to telehealth services, including interpretative services, for originating sites under this subsection. Such regulations shall allow an originating site to accept, and not duplicate, the credentialing and privileging processes and decisions made by another site.

''(B) CLARIFICATION REGARDING ACCEPTANCE OF PROCESSES AND DECISIONS PRIOR TO ENACTMENT OF REGULATIONS.—During the period beginning on such date of enactment and ending on the effective date of the regulations under subparagraph (A), the Secretary shall not take any punitive action under any rule or regulation against an originating site on the basis of that site's acceptance, for purposes of receiving telehealth services (including interpretive services), the credentialing and privileging processes and decisions made by another site that is certified by a national body recognized by the Secretary if the site accepting such credentialing and privileging processes is also so certified and complies with the applicable requirements for such acceptance.''.

(b) EXPANDING ACCESS TO STROKE TELEHEALTH EVALUATION.—

(1) IN GENERAL.—Section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)) is amended by adding at the end the following new subparagraph:

''(G) STROKE TELEHEALTH SERVICES.—The term 'stroke telehealth services' means a telehealth service used for the evaluation of individuals with acute stroke.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to telehealth services furnished on or after the date that is 6 months after the date of enactment of this Act.

(c) IMPROVING ACCESS TO TELEHEALTH SERVICES AT IHS FACILITIES.—

(1) COVERAGE OF METROPOLITAN SITES.—Section 1834(m)(4)(C)(i) of such Act (42 U.S.C. 1395m(m)(4)(C)(i)) is amended—

(A) in subclause (II), by deleting ''or'' at the end;

(B) in subclause (III), by deleting the period at the end and inserting ''; or''; and

(C) by adding at the end the following subclause:

''(IV) from a facility of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as

those terms are defined in section 4 of the Indian Health Care Improvement Act)).''.

(2) INCLUSION OF IHS FACILITIES AS ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

''(IX) A facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to telehealth services furnished on or after the date that is 6 months after the date of enactment of this Act.

(d) COMMUNITY-BASED PATIENT MONITORING.—Section 3026(B) of this Act is amended by adding at the end the following new clause:

''(vi) Utilizing telehealth, remote patient monitoring, and other technology when medically appropriate to enhance care transition services provided across the continuum of care.''.

(e) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) in the heading, by adding at the end the following: ''TELEHEALTH ADVISORY COMMITTEE''; and

(B) by adding at the end the following new subsection:

''(c) TELEHEALTH ADVISORY COMMITTEE.—

''(1) IN GENERAL.—A Telehealth Advisory Committee (in this subsection referred to as the 'Advisory Committee') shall be appointed by the Secretary to make annual recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section, and to Congress on areas in which originating sites are located (as specified in paragraph (4)(C)(i) of such section) and eligible telehealth sites (as described in paragraph (4)(C)(ii) of such section).

''(2) MEMBERSHIP; TERMS.—

''(A) MEMBERSHIP.—

''(i) IN GENERAL.—The Advisory Committee shall be composed of 10 members, to be appointed by the Secretary, of whom—

''(I) 5 shall be practicing physicians;

''(II) 2 shall be practicing nonphysician health care practitioners;

''(III) 2 shall be administrators of telehealth programs; and

''(IV) 1 shall be an informatics or technology expert.

''(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

''(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

''(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

''(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

''(IV) take into account the recommendations of stakeholders.

''(B) TERMS.—The members of the Advisory Committee shall serve for a 3-year term.

''(C) CONFLICTS OF INTEREST.—A member of the Advisory Committee may not participate with respect to a particular matter considered in a meeting of the Advisory Committee if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

''(D) PRIORITY AREAS FOR CONSIDERATION.—In making recommendations under paragraph (1), the committee shall consider recommendations to Congress on the following:

''(i) Increasing coverage of telehealth services to all geographic areas of the United States. Such consideration shall take into account the costs to the Federal Government of such increased coverage and the total offsetting savings accrued to the Federal Government as a result of investments in telehealth.

''(ii) Including providing payments under section 1834(m) for store and forward services for all eligible areas. Such consideration should take into account the experience in Alaska and Hawaii in providing such services under this title, including the impact on costs, the effect on the quality and availability of health services, and ways in which the Federal Government can minimize the risk of fraud and abuse for such services.

''(iii) Expanding coverage under this title of remote monitoring services for—

''(I) individuals with chronic diseases;

''(II) individuals recently discharged from a facility that is an originating site under such section; and

''(III) individuals assigned to an accountable care organization under section 1899, individuals discharged from a hospital that receives disproportionate share payments under section 1886(d)(5)(F) who are in need of transitional care, and individuals who are furnished services under the national pilot program on payment bundling under section 1866D.

Each recommendation made under paragraph (1) shall take into consideration the costs to the Federal Government and the total offsetting savings accrued to the Federal Government as a result of investments in telehealth and ways in which the Federal Government can minimize the risk of fraud and abuse for telehealth services.

''(3) REQUIREMENT TO REVIEW AND PROVIDE RECOMMENDATIONS.—The Advisory Committee shall review and provide recommendations to the Secretary on legislation that would allow other providers of services and suppliers to provide telehealth services to Medicare beneficiaries.

''(4) DEADLINE.—Not later than December 31, 2010, the Advisory Committee shall submit to Congress any recommendations to Congress under paragraph (1), including the recommendations considered under paragraph (2)(D).''.

(2) FOLLOWING RECOMMENDATIONS.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

''(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.''.

(3) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

(f) LIST OF COVERED TELEHEALTH SERVICES.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)), as amended by subsection (e), is further amended—

(1) by redesignating clauses (ii) and (iii) as clauses (iii) and (iv);

(2) by inserting after clause (i) the following new clause:

''(ii) ORIGINATING SITE SERVICES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may make payments under this subsection to an originating site described in subparagraph (C)(ii) for services originating at the site.

''(II) LIMITATION.—The Secretary may not make such payments with respect to a service described in subclause (I) if the Secretary finds, upon review of the available evidence, that a service is not safe, effective, or medically beneficial when performed as a telehealth service.''; and

(3) by striking clause (iii), as redesignated under paragraph (1), and inserting the following new clause:

''(iii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis—

''(I) for the addition of telehealth services (and HCPCS codes), to those specified in clauses (i) and (ii) for authorized payment under this subsection, unless the Secretary finds, upon review of the available evidence, that a service is not safe, effective, or medically beneficial when performed as a telehealth service; and

''(II) for the deletion of such services (and HCPCS codes), from those specified in clauses (i) and (ii) for authorized payment under this subsection, that the Secretary finds, upon review of additional evidence, are not safe, effective, or medically beneficial when performed as a telehealth service.''.

(g) TELEHEALTH ACCESS TO SMALL POPULATION METROPOLITAN COUNTIES.—Section 1834(m)(4)(C)(i)(II) of such Act (42 U.S.C. 1395m(4)(C)(i)(II)) is amended to read as follows:

''(II) in a county with a population of less than 35,000, according to the most recent decennial census, or that is not included in a Metropolitan Statistical Area; or''.

(h) TELEHEALTH ACCESS FOR ''STORE AND FORWARD'' DIAGNOSTIC CONSULTATIONS.—Section 1834(m)(1) of such Act (42 U.S.C. 1395(m)(1)) is amended by adding at the end the following sentence: ''For purposes of the first sentence, in the case of telehealth services that are furnished by a facility of the Indian Health Service, a rural health clinic, a Federally qualified health center, or a critical access hospital (as described in paragraph (4)(C)(ii)) , or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), the term 'telecommunications system' includes store-and-forward technologies described in the preceding sentence.''.

SA 3137. Mr. BEGICH 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 1339, between lines 18 and 19, insert the following:

SEC. 5211. INCREASING ACCESS TO PRIMARY CARE SERVICES.

(a) STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.—

(1) IN GENERAL.—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

(2) SOURCE OF FUNDS.—A grant program established by a State under paragraph (1) may not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under paragraph (1).

(b) PROVIDING FOR UNDERSERVED MEDICARE POPULATIONS DEMONSTRATION PROJECT.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 2541 et seq.) is amended by adding at the end the following:

"SEC. 338N. PROVIDING FOR UNDERSERVED MEDICARE POPULATIONS DEMONSTRATION PROJECT.

''(a) IN GENERAL.—The Secretary shall establish, in not more than 5 States, a demonstration project, to be known as the Providing for Underserved Medicare Populations Demonstration Project, for the purpose of encouraging health care providers who are recent graduates of a health care program to enter into primary care practice, by providing incentive payments to eligible primary health services providers.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—The Secretary shall grant awards, on a competitive basis, to eligible primary health services providers, as described in paragraph (2). Each recipient of such an award shall receive such award for a period of 3 years, provided such recipient continues to meet the eligibility criteria described in subsection (c).

''(2) AWARD AMOUNTS.—Each award described in paragraph (1) shall be in an amount not to exceed—

''(A) $50,000 per year for the repayment of student loans associated with the health care educational expenses of such recipient; or

''(B) $37,500 per year in cash incentive payments.

''(c) ELIGIBLE PRIMARY HEALTH SERVICES PROVIDERS.—The Secretary shall establish criteria for individuals to be eligible to receive an award under this section, which shall include requirements that such individual—

''(1) be actively employed as a primary health services provider, or have arrangements to commence active employment as a primary health services provider, in one of the 5 States that the Secretary has selected for participation in this demonstration project and in a community with a population of not less than 35,000 and not more than 350,000 and not designated as a health professional shortage area;

''(2) have graduated, not more than 2 years after the date on which such individual would begin receiving incentive payments under this project, from an accredited program that qualifies such individual to maintain employment as a primary health services provider;

''(3) agree that, of the patients receiving care from such primary health services provider in the period during which such individual participates in the project, not less than 60 percent of such patients shall be enrolled in the Medicare program under title XVIII of the Social Security Act;

''(4) be employed, as described in paragraph (1), in a State in which the 65-and-over population is expected to grow at least 50 percent between 2010 and 2020, according to United States Census Bureau projections; and

''(5) meet such other eligibility criteria established by the Secretary.

''(d) DURATION OF PROGRAM.—The Secretary shall make initial awards to individuals under this section for each of fiscal years 2011 through 2013.

''(e) REPORT.—Not later than December 31, 2015, the Secretary shall submit to Congress a report concerning the results of the demonstration project.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $25,000,000 for fiscal years 2011 through 2015.''.

(c) FACULTY LOAN REPAYMENT FOR PHYSICIAN ASSISTANTS.—Section 738(a)(3) of the Public Health Service Act (42 U.S.C.293b(a)(3)) is amended by inserting ''schools offering physician assistant education programs,'' after ''public health,''.

(d) NATIONAL HEALTH SERVICE CORPS.—

(1) FULFILLMENT OF OBLIGATED SERVICE REQUIREMENT THROUGH HALF-TIME SERVICE.—

(A) WAIVERS.—Subsection (i) of section 331 (42 U.S.C. 254d) is amended—

(i) in paragraph (1), by striking ''In carrying out subpart III'' and all that follows through the period and inserting ''In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half time.'';

(ii) in paragraph (2)—

(I) in subparagraphs (A)(ii) and (B), by striking ''less than full time'' each place it appears and inserting ''half time'';

(II) in subparagraphs (C) and (F), by striking ''less than full-time service'' each place it appears and inserting ''half-time service''; and

(III) by amending subparagraphs (D) and (E) to read as follows:

''(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

''(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

''(i) double the period of obligated service that would otherwise be required; or

''(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and''; and

(iii) in paragraph (3), by striking ''In evaluating a demonstration project described in paragraph (1)'' and inserting ''In evaluating waivers issued under paragraph (1)''.

(B) DEFINITIONS.—Subsection (j) of section 331 (42 U.S.C. 254d) is amended by adding at the end the following:

''(5) The terms 'full time' and 'full-time' mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

''(6) The terms 'half time' and 'half-time' mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.''.

(2) REAPPOINTMENT TO NATIONAL ADVISORY COUNCIL.—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amended by striking ''Members may not be reappointed to the Council.''.

(3) LOAN REPAYMENT AMOUNT.—Section 338B(g)(2)(A) (42 U.S.C. 2541–1(g)(2)(A)) is amended by striking ''$35,000'' and inserting ''$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation,''.

(4) TREATMENT OF TEACHING AS OBLIGATED SERVICE.—Subsection (a) of section 338C (42 U.S.C. 254m) is amended by adding at the end the following: ''The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.''.

SA 3138. Mrs. HUTCHISON (for herself and Mr. HATCH) 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 sections 2551 and 3133.

SA 3139. Mrs. HUTCHISON 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 354, between lines 2 and 3, insert the following:

(D) EXEMPTION FOR EMPLOYERS IN STATES WITH HIGH PREMIUM INCREASES.—

(i) IN GENERAL.—If a State is described in clause (ii), then, on and after the certification date, no employer in such State shall be treated as an applicable large employer for purposes of this section.

(ii) STATE DESCRIBED.—For purposes of this subparagraph—

(I) IN GENERAL.—A State is described in this clause if the applicable State authority determines for any calendar year after 2013 that the percentage increase in average annual premiums for health insurance coverage in such State for the calendar year over the preceding calendar year exceeds the percentage increase for such period in the Consumer Price Index for all urban consumers published by the Department of Labor.

(II) CERTIFICATION DATE.—The term ''certification date'' means the first date on which the applicable State authority certifies a determination described in subclause (I).

(III) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' has the meaning given such term by section 2791(d)(1) of the Public Health Service Act.

SA 3140. Mrs. HUTCHISON 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 339, between lines 16 and 17, insert the following:

''(g) LIMITATION.—

''(1) IN GENERAL.—This section shall not apply to any individual residing in a State where the Secretary makes the determination described in paragraph (2) for a taxable year.

''(2) DETERMINATION.—A determination described in this paragraph is a determination that the average cost of premiums for health insurance coverage within the State for the year involved has increase by a percentage that is greater than the percentage increase in the Consumer Price Index for the year.''.

SA 3141. Mrs. HUTCHISON 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:

TITLE __MEDICAL CARE ACCESS PROTECTION

SEC. __1. SHORT TITLE.

This title may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __2. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider in a medically underserved community, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services) in a medically underserved community.

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services in a medically underserved community, affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider who delivers services in a medically underserved community or a health care institution located in a medically underserved community regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider who delivers services in a medically underserved community or a health care institution located in a medically underserved community regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider who delivers services in a medically underserved community or a health care institution located in a medically underserved community, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this title, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICALLY UNDERSERVED COMMUNITY.—The term ''medically underserved community'' means a health manpower shortage area as designated under section 332 of the Public Health Service Act.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider who delivers services in a medically underserved community or a health care institution located in a medically underserved community. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. _3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this title applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. _4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. _5. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. _6. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. _7. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may

allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __8. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. __9. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __10. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section ____4(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this title;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __11. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3142. Mrs. HUTCHISON 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 DEVICES FOR CANCER DIAGNOSIS AND TREATMENT.—

(1) IN GENERAL.—The term ''medical device sales'' shall not include sales of any device which is primarily designed to diagnose or treat any form of cancer.

(2) REDUCTION OF AGGREGATE FEE AMOUNT.—The $2,000,000,000 amount in subsection (b)(1) shall be reduced 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 calendar year 2010 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 3143. Mrs. HUTCHISON 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 I, insert the following:

SEC. ___. STATE OPT OUT.

(a) IN GENERAL.—The provisions described in subsection (b) shall not apply to

(1) individuals residing within a State;

(2) employers located within a State; and

(3) health coverage offered within a State;

if the State enacts a law rejecting such provisions as described in subsection (b) and attests to the Secretary that the State will implement reforms appropriate for application within the State to reduce the uninsured population of the State and increase access to affordable health insurance options.

(b) EFFECT OF STATE LAW.—The provisions described in this subsection are the following:

(1) The insurance market reform provisions of title I (and the amendments made by such title), except for section 2704 of the Public Health Service Act (as added by section 1201 (relating to preexisting condition exclusions).

(2) The requirements relating to obtaining or providing individual and employer health insurance coverage under title I (and the amendments made by such title).

(3) The provisions relating to Medicaid expansion under the amendments made by title I.

(4) The provisions relating to the Medicare program (and the amendments to such program) under title III and (IV).

(5) The provisions relating to the imposition of, or increases in, fees paid by insurance issuers and drug and medical device manufacturers under the amendments made by this Act.

(6) Any other provision of this Act (or an amendment made by this Act), except for this section.

(c) ABOVE-THE-LINE DEDUCTION FOR HEALTH INSURANCE PREMIUMS.—

(1) IN GENERAL.—Section 62(a) of the Internal Revenue Code of 1986 (defining adjusted gross income) is amended by inserting after paragraph (21) the following new paragraph:

''(22) HEALTH INSURANCE PAYMENTS.—

''(A) IN GENERAL.—Any amount allowable as a deduction under section 213 (determined without regard to any income limitation under subsection (a) thereof) by reason of subsection (d)(1)(D) thereof for qualified health insurance.

''(B) QUALIFIED HEALTH INSURANCE.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'qualified health insurance' means insurance offered to individuals located in a State that enacts a law described in section ___(a) of the Patient Protection and Affordable Care Act which constitutes medical care as defined in section 213(d) without regard to—

''(I) paragraph (1)(C) thereof, and

''(II) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(ii) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2009.

SA 3144. Mr. FRANKEN 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 VI, insert the following:

SEC. ___. ANTI-FRAUD CONSULTATION GROUP.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services jointly with the Attorney General shall establish an anti-fraud consultation group for the purpose of coordinating expertise and best practices relating to the analysis, detection, and prevention of fraud, waste, and abuse arising from, or related to, health care.

(b) COMPOSITION.—The anti-fraud consultation group under subsection (a) shall be composed of individuals, to be appointed jointly by the Secretary of Health and Human Services and the Attorney General, with expertise from both the public and private sectors in fraud arising from, or related to, health care, including law enforcement personnel, health insurance issuers, physicians and other health care providers, insurance anti-fraud organizations, academic experts, consumer groups, and insurance regulators.

(c) DUTIES.—At the request of the Secretary of Health and Human Services and the Attorney General, the anti-fraud consultation group under subsection (a) shall provide advice concerning—

(1) methods of preventing fraud against Federal and State health care programs, consumers, providers, employers, and health insurance issuers;

(2) the evaluation of information and data to improve the ability to detect and prevent fraud;

(3) the enhancement of anti-fraud information data systems, consistent with the protection of personal privacy; and

(4) the coordination of public and private resources in the analysis, detection, and prevention of fraud arising from, or related to, health care.

(d) ANNUAL REPORT.—The anti-fraud consultation group under subsection (a) shall, not later than 1 year after the date of enactment of this Act, and annually thereafter, submit to the Secretary of Health and Human Services and the Attorney General a report concerning the group's—

(1) accomplishments to improve the coordination of public and private health care anti-fraud actions;

(2) development of enhanced techniques for the analysis, detection, and prevention of fraud; and

(3) recommendations for the improvement of anti-fraud programs.

(e) FUNDING.—The Secretary and the Attorney General shall use funds appropriated to the Secretary or Attorney General prior to the date of enactment of this Act, and otherwise available, to carry out this section.

SA 3145. Mr. MCCONNELL (for himself, Mr. ENSIGN, and Mr. MCCAIN) 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:

In lieu of the matter proposed to be inserted, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this Act to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 3. DEFINITIONS.

In this Act:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out

of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this Act, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 4. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this Act applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 5. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this Act shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 6. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 7. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 8. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device''

have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 9. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

SEC. 10. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this Act shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this Act in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this Act or otherwise applicable law (as determined under this Act) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this Act shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this Act in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this Act or otherwise applicable law (as determined under this Act) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this Act shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this Act shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this Act shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, notwithstanding section 5(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this Act (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this Act;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

This Act shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3146. 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 340, between lines 14 and 15, insert the following:

''(g) PENALTIES CREDITED TO INDIVIDUAL ACCOUNTS AND USED FOR PREMIUMS.—

''(1) IN GENERAL.—The Secretary shall not later than January 1, 2014, establish and implement a program under which—

''(A) if a penalty has been imposed under this section with respect to an applicable individual for months during any calendar year, the Secretary—

''(i) establishes an account on behalf of the applicable individual, and

''(ii) credits such account with an amount equal to the amount of the penalty, and

''(B) if the applicable individual subsequently becomes covered under minimum essential coverage for 1 or more months, the Secretary pays to or on behalf of the applicable individual an amount equal to the premiums paid by the individual for such coverage (or, if lesser, the balance in the account established under subparagraph (A)).

''(2) AMOUNTS AVAILABLE ONLY FOR 3 YEARS.—

''(A) IN GENERAL.—If an account is credited under paragraph (1)(A) with an amount for any calendar year, such amount shall be available for payment under paragraph (1)(B) only for premiums for minimum essential coverage for months occurring during the 3 calendar years immediately following such calendar year.

''(B) SPECIAL RULES.—For purposes of this subsection—

''(i) the Secretary need only establish 1 account for an individual, and

''(ii) amounts shall be treated as paid out of an account on a first-in, first-out basis.''.

SA 3147. 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 339, between lines 12 and 13, insert the following:

''(5) HIGH DEDUCTIBLE HEALTH PLAN.—

''(A) IN GENERAL.—If an applicable individual—

''(i) is an employee of an employer who ceases to offer the employee the opportunity to enroll in an eligible employer-sponsored plan, or

''(ii) ceases employment with an employer and is not otherwise eligible to enroll in an eligible employer-sponsored plan,

the applicable individual may enroll in a high deductible health plan described in subparagraph (C) and such plan shall be treated as minimum essential coverage.

''(B) CONTINUED ENROLLMENT.—If an individual described in subparagraph (A) enrolls in a high deductible health plan described in subparagraph (C), such plan shall continue to be treated as minimum essential coverage with respect to that individual during any continuous period of enrollment even if the individual is otherwise eligible to enroll in an eligible employer-sponsored plan.

''(C) PLAN DESCRIBED.—A health plan is described in this subparagraph if it is a high deductible health plan (as defined in section 223(c)(2)) that meets all requirements under such section to be offered in connection with a health savings account. No requirement imposed by any provision of, or any amendment made by, the Patient Protection and Affordable Care Act shall apply with respect to the plan or issuer thereof.

SA 3148. 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 396, between lines 8 and 9, insert the following:

Subtitle H—Sunset if Premiums Increase Too Rapidly

SEC. 1601. SUNSET.

(a) IN GENERAL.—The following requirements shall not apply to health insurance coverage and group health plans offered in the individual or group market within a State during plan years beginning after the sunset date with respect to that market:

(1) Any requirement under section 1301 of this title, section 2707 of the Public Health Service Act, or any other provision of, or amendment made by, this title that a health plan provide an essential health benefits package described in section 1302(a) of this title, including any requirement that the plan provide—

(A) for essential health benefits described in section 1302(b);

(B) in the case of a plan offered in the group market, an annual limitation on the plan's deductible described in section 1302(c)(2); and

(C) a level of coverage described in section 1302(d).

(2) The requirements of section 2701 of the Public Health Service Act (relating to limits on premiums).

(b) COORDINATION WITH QUALIFIED HEALTH PLANS AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—In the case of a State to which subsection (a) applies, the Secretary shall establish procedures for establishing which health plans shall be treated as qualified health plans for purposes of the Exchanges established within such State. Such procedures shall ensure that the aggregate amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 with respect to qualified health plans in the individual market within such State does not exceed the aggregate amount of such credits and reductions that would have been allowed if subsection (a) did not apply to such State.

(c) SUNSET DATE.—For purposes of this section—

(1) IN GENERAL.—The term ''sunset date'' means, with respect to the individual or group market within a State, the first date on which the applicable State authority determines under paragraph (2) that the percentage increase in average annual premiums within such market for a calendar year over the preceding calendar year exceeds the percentage increase for such period in the Consumer Price Index for all urban consumers published by the Department of Labor.

(2) DETERMINATION.—The applicable State authority shall for each calendar year after 2013 make the determination described in paragraph (1).

(3) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' has the meaning given such term by section 2791(d)(1) of the Public Health Service Act.

SA 3149. 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 999, between lines 16 and 17, insert the following:

(q) BUDGET-NEUTRAL EXEMPTION OF CERTAIN PROVIDERS.—Notwithstanding the provisions of, and amendments made by, the preceding subsections of this section—

(1) such provisions and amendments shall not apply to a health care provider that—

(A) is described in section 340B(a)(4) of the Public Health Service Act or 1927(c)(1)(D)(i)(IV) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)); and

(B) is located in an area that is not a metropolitan statistical area (as determined by the Bureau of the Census); and

(2) the Secretary of Health and Human Services shall make appropriate adjustments in the application of such provisions and amendments to ensure that the amount of expenditures under title XVIII of the Social Security Act is equal to the amount of expenditures that would have been made under such title if this subsection had not been enacted, as estimated by the Secretary.

SA 3150. 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 186, strike line 23 and insert the following: ''plan. When establishing geographically adjusted premium rates under the preceding sentence, the Secretary shall not take into account direct graduate medical education payments, Medicare disproportionate share payments, and health information technology funding under the American Recovery and Reinvestment Act of 2009.''.

SA 3151. 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 201, between lines 6 and 7, insert the following:

SEC. 1325. PROHIBITION ON FEDERAL BAILOUT OF A CO-OP PLAN OR A COMMUNITY HEALTH INSURANCE OPTION.

(a) PROHIBITION.—Notwithstanding any provision of (or amendment made by) this Act, no Federal funds shall paid to, or used to support the operation of (including ensuring the solvency of), a qualified health plan offered under the Consumer Operated and Oriented Plan (CO-OP) program under section 1322 or a community health insurance option under section 1323.

(b) EXCEPTIONS.—Subsection (a) shall not apply to—

(1) loans and grants under section 1322(b) or loans or payments under section 1323(c); or

(2) any premium tax credit under section 36B of the Internal Revenue Code of 1986 or any cost-sharing reduction under section 1402, or any advance payment of either, with respect to an individual enrolled in a plan or option described in subsection (a).

SA 3152. 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:

TITLE ____—MEDICAL CARE ACCESS PROTECTION

SEC. __1. SHORT TITLE.

This title may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __2. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment

for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this title, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. __3. INCREASED FMAP FOR MEDICAL LIABILITY REFORM.

With respect to fiscal years 2011 and 2012, the Secretary of Health and Human Services shall increase by an amount equal to 2 percent of the total amount of Federal payments estimated to be made to a State under section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) for providing medical assistance for children under the State Medicaid program during the fiscal year if the Secretary determines that the State has enacted a law that substantially complies with this title.

SEC. __4. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this title applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. __5. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. __6. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. __7. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __8. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __9. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. __10. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under

this title) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section __5(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this title;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __12. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3153. 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 339, between lines 16 and 17, insert the following:

''(g) LIMITATION.—This section shall not apply to an individual for a taxable year if such individual—

''(1) in under 30 years of age when such year begins; or

''(2) has a modified gross income that does not exceed $30,000 for such year.''.

SA 3154. 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 2034, strike lines 8 through 15.

SA 3155. 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 201, between lines 6 and 7, insert the following:

SEC. 1325. ANNUAL AUDITS.

(a) IN GENERAL.—The Secretary shall enter into contracts with one or more private accounting firms for the conduct of annual audits of the CO-OP program under section 1322 and the community health insurance option program under section 1323. SUch contracts shall require that such firms submit annual reports to the Secretary concerning the results of such audits.

(b) INCLUSION IN MEDICARE TRUSTEES REPORT.—Sections 1817(b) and 1841(b) of the Social Security Act (42 U.S.C. 1395i(b); 1395t(b)) are each amended by inserting at the end the following new sentence: ''Each report submitted under paragraph (2) (beginning with the report for 2014) shall include a description of the results of the audits conducted under section 1325(a) of the Patient Protection and Affordable Care Act for the year involved.''.

SA 3156. Mr. LAUTENBERG (for himself, Mr. CARPER, and Mr. MENENDEZ) 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, add the following:

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 10001. SHORT TITLE.

This title may be cited as the ''Pharmaceutical Market Access and Drug Safety Act of 2009''.

SEC. 10002. FINDINGS.

Congress finds that—

(1) Americans unjustly pay up to 5 times more to fill their prescriptions than consumers in other countries;

(2) the United States is the largest market for pharmaceuticals in the world, yet American consumers pay the highest prices for brand pharmaceuticals in the world;

(3) a prescription drug is neither safe nor effective to an individual who cannot afford it;

(4) allowing and structuring the importation of prescription drugs to ensure access to safe and affordable drugs approved by the Food and Drug Administration will provide a level of safety to American consumers that they do not currently enjoy;

(5) American spend more than $200,000,000,000 on prescription drugs every year;

(6) the Congressional Budget Office has found that the cost of prescription drugs are between 35 to 55 percent less in other highly-developed countries than in the United States; and

(7) promoting competitive market pricing would both contribute to health care savings and allow greater access to therapy, improving health and saving lives.

SEC. 10003. REPEAL OF CERTAIN SECTION REGARDING IMPORTATION OF PRESCRIPTION DRUGS.

Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804.

SEC. 10004. IMPORTATION OF PRESCRIPTION DRUGS; WAIVER OF CERTAIN IMPORT RESTRICTIONS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10003, is further amended by inserting after section 803 the following:

''SEC. 804. COMMERCIAL AND PERSONAL IMPORTATION OF PRESCRIPTION DRUGS.

''(a) IMPORTATION OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—In the case of qualifying drugs imported or offered for import into the United States from registered exporters or by registered importers—

''(A) the limitation on importation that is established in section 801(d)(1) is waived; and

''(B) the standards referred to in section 801(a) regarding admission of the drugs are subject to subsection (g) of this section (including with respect to qualifying drugs to which section 801(d)(1) does not apply).

''(2) IMPORTERS.—A qualifying drug may not be imported under paragraph (1) unless—

''(A) the drug is imported by a pharmacy, group of pharmacies, or a wholesaler that is a registered importer; or

''(B) the drug is imported by an individual for personal use or for the use of a family

member of the individual (not for resale) from a registered exporter.

''(3) RULE OF CONSTRUCTION.—This section shall apply only with respect to a drug that is imported or offered for import into the United States—

''(A) by a registered importer; or

''(B) from a registered exporter to an individual.

''(4) DEFINITIONS.—

''(A) REGISTERED EXPORTER; REGISTERED IMPORTER.—For purposes of this section:

''(i) The term 'registered exporter' means an exporter for which a registration under subsection (b) has been approved and is in effect.

''(ii) The term 'registered importer' means a pharmacy, group of pharmacies, or a wholesaler for which a registration under subsection (b) has been approved and is in effect.

''(iii) The term 'registration condition' means a condition that must exist for a registration under subsection (b) to be approved.

''(B) QUALIFYING DRUG.—For purposes of this section, the term 'qualifying drug' means a drug for which there is a corresponding U.S. label drug.

''(C) U.S. LABEL DRUG.—For purposes of this section, the term 'U.S. label drug' means a prescription drug that—

''(i) with respect to a qualifying drug, has the same active ingredient or ingredients, route of administration, dosage form, and strength as the qualifying drug;

''(ii) with respect to the qualifying drug, is manufactured by or for the person that manufactures the qualifying drug;

''(iii) is approved under section 505(c); and

''(iv) is not—

''(I) a controlled substance, as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802);

''(II) a biological product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262), including—

''(aa) a therapeutic DNA plasmid product;

''(bb) a therapeutic synthetic peptide product;

''(cc) a monoclonal antibody product for in vivo use; and

''(dd) a therapeutic recombinant DNA-derived product;

''(III) an infused drug, including a peritoneal dialysis solution;

''(IV) an injected drug;

''(V) a drug that is inhaled during surgery;

''(VI) a drug that is the listed drug referred to in 2 or more abbreviated new drug applications under which the drug is commercially marketed; or

''(VII) a sterile opthlamic drug intended for topical use on or in the eye.

''(D) OTHER DEFINITIONS.—For purposes of this section:

''(i)(I) The term 'exporter' means a person that is in the business of exporting a drug to individuals in the United States from Canada or from a permitted country designated by the Secretary under subclause (II), or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.

''(II) The Secretary shall designate a permitted country under subparagraph (E) (other than Canada) as a country from which an exporter may export a drug to individuals in the United States if the Secretary determines that—

''(aa) the country has statutory or regulatory standards that are equivalent to the standards in the United States and Canada with respect to—

''(AA) the training of pharmacists;

''(BB) the practice of pharmacy; and

''(CC) the protection of the privacy of personal medical information; and

''(bb) the importation of drugs to individuals in the United States from the country will not adversely affect public health.

''(ii) The term 'importer' means a pharmacy, a group of pharmacies, or a wholesaler that is in the business of importing a drug into the United States or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.

''(iii) The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(iv) The term 'pharmacy' means a person that—

''(I) is licensed by a State to engage in the business of selling prescription drugs at retail; and

''(II) employs 1 or more pharmacists.

''(v) The term 'prescription drug' means a drug that is described in section 503(b)(1).

''(vi) The term 'wholesaler'—

''(I) means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A); and

''(II) does not include a person authorized to import drugs under section 801(d)(1).

''(E) PERMITTED COUNTRY.—The term 'permitted country' means—

''(i) Australia;

''(ii) Canada;

''(iii) a member country of the European Union, but does not include a member country with respect to which—

''(I) the country's Annex to the Treaty of Accession to the European Union 2003 includes a transitional measure for the regulation of human pharmaceutical products that has not expired; or

''(II) the Secretary determines that the requirements described in subclauses (I) and (II) of clause (vii) will not be met by the date on which such transitional measure for the regulation of human pharmaceutical products expires;

''(iv) Japan;

''(v) New Zealand;

''(vi) Switzerland; and

''(vii) a country in which the Secretary determines the following requirements are met:

''(I) The country has statutory or regulatory requirements—

''(aa) that require the review of drugs for safety and effectiveness by an entity of the government of the country;

''(bb) that authorize the approval of only those drugs that have been determined to be safe and effective by experts employed by or acting on behalf of such entity and qualified by scientific training and experience to evaluate the safety and effectiveness of drugs on the basis of adequate and well-controlled investigations, including clinical investigations, conducted by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs;

''(cc) that require the methods used in, and the facilities and controls used for the manufacture, processing, and packing of drugs in the country to be adequate to preserve their identity, quality, purity, and strength;

''(dd) for the reporting of adverse reactions to drugs and procedures to withdraw approval and remove drugs found not to be safe or effective; and

''(ee) that require the labeling and promotion of drugs to be in accordance with the approval of the drug.

''(II) The valid marketing authorization system in the country is equivalent to the systems in the countries described in clauses (i) through (vi).

''(III) The importation of drugs to the United States from the country will not adversely affect public health.

''(b) REGISTRATION OF IMPORTERS AND EXPORTERS.—

''(1) REGISTRATION OF IMPORTERS AND EXPORTERS.—A registration condition is that the importer or exporter involved (referred to in this subsection as a 'registrant') submits to the Secretary a registration containing the following:

''(A)(i) In the case of an exporter, the name of the exporter and an identification of all places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter.

''(ii) In the case of an importer, the name of the importer and an identification of the places of business of the importer at which the importer initially receives a qualifying drug after importation (which shall not exceed 3 places of business except by permission of the Secretary).

''(B) Such information as the Secretary determines to be necessary to demonstrate that the registrant is in compliance with registration conditions under—

''(i) in the case of an importer, subsections (c), (d), (e), (g), and (j) (relating to the sources of imported qualifying drugs; the inspection of facilities of the importer; the payment of fees; compliance with the standards referred to in section 801(a); and maintenance of records and samples); or

''(ii) in the case of an exporter, subsections (c), (d), (f), (g), (h), (i), and (j) (relating to the sources of exported qualifying drugs; the inspection of facilities of the exporter and the marking of compliant shipments; the payment of fees; and compliance with the standards referred to in section 801(a); being licensed as a pharmacist; conditions for individual importation; and maintenance of records and samples).

''(C) An agreement by the registrant that the registrant will not under subsection (a) import or export any drug that is not a qualifying drug.

''(D) An agreement by the registrant to—

''(i) notify the Secretary of a recall or withdrawal of a qualifying drug distributed in a permitted country that the registrant has exported or imported, or intends to export or import, to the United States under subsection (a);

''(ii) provide for the return to the registrant of such drug; and

''(iii) cease, or not begin, the exportation or importation of such drug unless the Secretary has notified the registrant that exportation or importation of such drug may proceed.

''(E) An agreement by the registrant to ensure and monitor compliance with each registration condition, to promptly correct any noncompliance with such a condition, and to promptly report to the Secretary any such noncompliance.

''(F) A plan describing the manner in which the registrant will comply with the agreement under subparagraph (E).

''(G) An agreement by the registrant to enforce a contract under subsection (c)(3)(B) against a party in the chain of custody of a qualifying drug with respect to the authority of the Secretary under clauses (ii) and (iii) of that subsection.

''(H) An agreement by the registrant to notify the Secretary not more than 30 days before the registrant intends to make the change, of—

''(i) any change that the registrant intends to make regarding information provided under subparagraph (A) or (B); and

''(ii) any change that the registrant intends to make in the compliance plan under subparagraph (F).

''(I) In the case of an exporter:

''(i) An agreement by the exporter that a qualifying drug will not under subsection (a)

be exported to any individual not authorized pursuant to subsection (a)(2)(B) to be an importer of such drug.

''(ii) An agreement to post a bond, payable to the Treasury of the United States that is equal in value to the lesser of—

''(I) the value of drugs exported by the exporter to the United States in a typical 4-week period over the course of a year under this section; or

''(II) $1,000,000.

''(iii) An agreement by the exporter to comply with applicable provisions of Canadian law, or the law of the permitted country designated under subsection (a)(4)(D)(i)(II) in which the exporter is located, that protect the privacy of personal information with respect to each individual importing a prescription drug from the exporter under subsection (a)(2)(B).

''(iv) An agreement by the exporter to report to the Secretary—

''(I) not later than August 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the 6-month period from January 1 through June 30 of that year; and

''(II) not later than January 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the previous fiscal year.

''(J) In the case of an importer, an agreement by the importer to report to the Secretary—

''(i) not later than August 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the 6-month period from January 1 through June 30 of that fiscal year; and

''(ii) not later than January 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the previous fiscal year.

''(K) Such other provisions as the Secretary may require by regulation to protect the public health while permitting—

''(i) the importation by pharmacies, groups of pharmacies, and wholesalers as registered importers of qualifying drugs under subsection (a); and

''(ii) importation by individuals of qualifying drugs under subsection (a).

''(2) APPROVAL OR DISAPPROVAL OF REGISTRATION.—

''(A) IN GENERAL.—Not later than 90 days after the date on which a registrant submits to the Secretary a registration under paragraph (1), the Secretary shall notify the registrant whether the registration is approved or is disapproved. The Secretary shall disapprove a registration if there is reason to believe that the registrant is not in compliance with one or more registration conditions, and shall notify the registrant of such reason. In the case of a disapproved registration, the Secretary shall subsequently notify the registrant that the registration is approved if the Secretary determines that the registrant is in compliance with such conditions.

''(B) CHANGES IN REGISTRATION INFORMATION.—Not later than 30 days after receiving a notice under paragraph (1)(H) from a registrant, the Secretary shall determine whether the change involved affects the approval of the registration of the registrant under paragraph (1), and shall inform the registrant of the determination.

''(3) PUBLICATION OF CONTACT INFORMATION FOR REGISTERED EXPORTERS.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall make readily available to the public a list of registered exporters, including contact information for the exporters. Promptly after the approval of a registration submitted under paragraph (1), the Secretary shall update the Internet website and the information provided through the toll-free telephone number accordingly.

''(4) SUSPENSION AND TERMINATION.—

''(A) SUSPENSION.—With respect to the effectiveness of a registration submitted under paragraph (1):

''(i) Subject to clause (ii), the Secretary may suspend the registration if the Secretary determines, after notice and opportunity for a hearing, that the registrant has failed to maintain substantial compliance with a registration condition.

''(ii) If the Secretary determines that, under color of the registration, the exporter has exported a drug or the importer has imported a drug that is not a qualifying drug, or a drug that does not comply with subsection (g)(2)(A) or (g)(4), or has exported a qualifying drug to an individual in violation of subsection (i), the Secretary shall immediately suspend the registration. A suspension under the preceding sentence is not subject to the provision by the Secretary of prior notice, and the Secretary shall provide to the registrant an opportunity for a hearing not later than 10 days after the date on which the registration is suspended.

''(iii) The Secretary may reinstate the registration, whether suspended under clause (i) or (ii), if the Secretary determines that the registrant has demonstrated that further violations of registration conditions will not occur.

''(B) TERMINATION.—The Secretary, after notice and opportunity for a hearing, may terminate the registration under paragraph (1) of a registrant if the Secretary determines that the registrant has engaged in a pattern or practice of violating 1 or more registration conditions, or if on 1 or more occasions the Secretary has under subparagraph (A)(ii) suspended the registration of the registrant. The Secretary may make the termination permanent, or for a fixed period of not less than 1 year. During the period in which the registration is terminated, any registration submitted under paragraph (1) by the registrant, or a person that is a partner in the export or import enterprise, or a principal officer in such enterprise, and any registration prepared with the assistance of the registrant or such a person, has no legal effect under this section.

''(5) DEFAULT OF BOND.—A bond required to be posted by an exporter under paragraph (1)(I)(ii) shall be defaulted and paid to the Treasury of the United States if, after opportunity for an informal hearing, the Secretary determines that the exporter has—

''(A) exported a drug to the United States that is not a qualifying drug or that is not in compliance with subsection (g)(2)(A), (g)(4), or (i); or

''(B) failed to permit the Secretary to conduct an inspection described under subsection (d).

''(c) SOURCES OF QUALIFYING DRUGS.—A registration condition is that the exporter or importer involved agrees that a qualifying drug will under subsection (a) be exported or imported into the United States only if there is compliance with the following:

''(1) The drug was manufactured in an establishment—

''(A) required to register under subsection (h) or (i) of section 510; and

''(B)(i) inspected by the Secretary; or

''(ii) for which the Secretary has elected to rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided for under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(2) The establishment is located in any country, and the establishment manufactured the drug for distribution in the United States or for distribution in 1 or more of the permitted countries (without regard to whether in addition the drug is manufactured for distribution in a foreign country that is not a permitted country).

''(3) The exporter or importer obtained the drug—

''(A) directly from the establishment; or

''(B) directly from an entity that, by contract with the exporter or importer—

''(i) provides to the exporter or importer a statement (in such form and containing such information as the Secretary may require) that, for the chain of custody from the establishment, identifies each prior sale, purchase, or trade of the drug (including the date of the transaction and the names and addresses of all parties to the transaction);

''(ii) agrees to permit the Secretary to inspect such statements and related records to determine their accuracy;

''(iii) agrees, with respect to the qualifying drugs involved, to permit the Secretary to inspect warehouses and other facilities, including records, of the entity for purposes of determining whether the facilities are in compliance with any standards under this Act that are applicable to facilities of that type in the United States; and

''(iv) has ensured, through such contractual relationships as may be necessary, that the Secretary has the same authority regarding other parties in the chain of custody from the establishment that the Secretary has under clauses (ii) and (iii) regarding such entity.

''(4)(A) The foreign country from which the importer will import the drug is a permitted country; or

''(B) The foreign country from which the exporter will export the drug is the permitted country in which the exporter is located.

''(5) During any period in which the drug was not in the control of the manufacturer of the drug, the drug did not enter any country that is not a permitted country.

''(6) The exporter or importer retains a sample of each lot of the drug for testing by the Secretary.

''(d) INSPECTION OF FACILITIES; MARKING OF SHIPMENTS.—

''(1) INSPECTION OF FACILITIES.—A registration condition is that, for the purpose of assisting the Secretary in determining whether the exporter involved is in compliance with all other registration conditions—

''(A) the exporter agrees to permit the Secretary—

''(i) to conduct onsite inspections, including monitoring on a day-to-day basis, of places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter;

''(ii) to have access, including on a day-to-day basis, to—

''(I) records of the exporter that relate to the export of such drugs, including financial records; and

''(II) samples of such drugs;

''(iii) to carry out the duties described in paragraph (3); and

''(iv) to carry out any other functions determined by the Secretary to be necessary regarding the compliance of the exporter; and

''(B) the Secretary has assigned 1 or more employees of the Secretary to carry out the functions described in this subsection for the Secretary randomly, but not less than 12 times annually, on the premises of places of businesses referred to in subparagraph (A)(i),

and such an assignment remains in effect on a continuous basis.

''(2) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the exporter involved agrees to affix to each shipping container of qualifying drugs exported under subsection (a) such markings as the Secretary determines to be necessary to identify the shipment as being in compliance with all registration conditions. Markings under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings to any shipping container that is not authorized to bear the markings; and

''(B) include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies.

''(3) CERTAIN DUTIES RELATING TO EXPORTERS.—Duties of the Secretary with respect to an exporter include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the exporter at which qualifying drugs are stored and from which qualifying drugs are shipped.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the exporter, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an exporter.

''(C) Randomly reviewing records of exports to individuals for the purpose of determining whether the drugs are being imported by the individuals in accordance with the conditions under subsection (i). Such reviews shall be conducted in a manner that will result in a statistically significant determination of compliance with all such conditions.

''(D) Monitoring the affixing of markings under paragraph (2).

''(E) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records, of other parties in the chain of custody of qualifying drugs.

''(F) Determining whether the exporter is in compliance with all other registration conditions.

''(4) PRIOR NOTICE OF SHIPMENTS.—A registration condition is that, not less than 8 hours and not more than 5 days in advance of the time of the importation of a shipment of qualifying drugs, the importer involved agrees to submit to the Secretary a notice with respect to the shipment of drugs to be imported or offered for import into the United States under subsection (a). A notice under the preceding sentence shall include—

''(A) the name and complete contact information of the person submitting the notice;

''(B) the name and complete contact information of the importer involved;

''(C) the identity of the drug, including the established name of the drug, the quantity of the drug, and the lot number assigned by the manufacturer;

''(D) the identity of the manufacturer of the drug, including the identity of the establishment at which the drug was manufactured;

''(E) the country from which the drug is shipped;

''(F) the name and complete contact information for the shipper of the drug;

''(G) anticipated arrival information, including the port of arrival and crossing location within that port, and the date and time;

''(H) a summary of the chain of custody of the drug from the establishment in which the drug was manufactured to the importer;

''(I) a declaration as to whether the Secretary has ordered that importation of the drug from the permitted country cease under subsection (g)(2)(C) or (D); and

''(J) such other information as the Secretary may require by regulation.

''(5) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the importer involved agrees, before wholesale distribution (as defined in section 503(e)) of a qualifying drug that has been imported under subsection (a), to affix to each container of such drug such markings or other technology as the Secretary determines necessary to identify the shipment as being in compliance with all registration conditions, except that the markings or other technology shall not be required on a drug that bears comparable, compatible markings or technology from the manufacturer of the drug. Markings or other technology under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings or other technology to any container that is not authorized to bear the markings; and

''(B) shall include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of such technologies.

''(6) CERTAIN DUTIES RELATING TO IMPORTERS.—Duties of the Secretary with respect to an importer include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the importer at which a qualifying drug is initially received after importation.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the importer, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an importer.

''(C) Reviewing notices under paragraph (4).

''(D) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records of other parties in the chain of custody of qualifying drugs.

''(E) Determining whether the importer is in compliance with all other registration conditions.

''(e) IMPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the importer involved pays to the Secretary a fee of $10,000 due on the date on which the importer first submits the registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the importer involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for importers for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered importers, including the costs associated with—

''(i) inspecting the facilities of registered importers, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(6);

''(ii) developing, implementing, and operating under such subsection an electronic system for submission and review of the notices required under subsection (d)(4) with respect to shipments of qualifying drugs under subsection (a) to assess compliance with all registration conditions when such shipments are offered for import into the United States; and

''(iii) inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered importers under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during that fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered importers during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered importer on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL IMPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an importer shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the importer of the volume of qualifying drugs imported by importers under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(f) EXPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the exporter involved pays to the Secretary a fee of $10,000 due on the date on which the exporter first submits that registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the exporter involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for exporters for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered exporters, including the costs associated with—

''(i) inspecting the facilities of registered exporters, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(3);

''(ii) developing, implementing, and operating under such subsection a system to screen marks on shipments of qualifying drugs under subsection (a) that indicate compliance with all registration conditions, when such shipments are offered for import into the United States; and

''(iii) screening such markings, and inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered exporters under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during that fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered exporters during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered exporter on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL EXPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an exporter shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the exporter of the volume of qualifying drugs exported by exporters under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(g) COMPLIANCE WITH SECTION 801(a).—

''(1) IN GENERAL.—A registration condition is that each qualifying drug exported under subsection (a) by the registered exporter involved or imported under subsection (a) by the registered importer involved is in compliance with the standards referred to in section 801(a) regarding admission of the drug into the United States, subject to paragraphs (2), (3), and (4).

''(2) SECTION 505; APPROVAL STATUS.—

''(A) IN GENERAL.—A qualifying drug that is imported or offered for import under subsection (a) shall comply with the conditions established in the approved application under section 505(b) for the U.S. label drug as described under this subsection.

''(B) NOTICE BY MANUFACTURER; GENERAL PROVISIONS.—

''(i) IN GENERAL.—The person that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country shall in accordance with this paragraph submit to the Secretary a notice that—

''(I) includes each difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling); or

''(II) states that there is no difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling).

''(ii) INFORMATION IN NOTICE.—A notice under clause (i)(I) shall include the information that the Secretary may require under section 506A, any additional information the Secretary may require (which may include data on bioequivalence if such data are not required under section 506A), and, with respect to the permitted country that approved the qualifying drug for commercial distribution, or with respect to which such approval is sought, include the following:

''(I) The date on which the qualifying drug with such difference was, or will be, introduced for commercial distribution in the permitted country.

''(II) Information demonstrating that the person submitting the notice has also notified the government of the permitted country in writing that the person is submitting to the Secretary a notice under clause (i)(I), which notice describes the difference in the qualifying drug from a condition established in the approved application for the U.S. label drug.

''(III) The information that the person submitted or will submit to the government of the permitted country for purposes of obtaining approval for commercial distribution of the drug in the country which, if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation.

''(iii) CERTIFICATIONS.—The chief executive officer and the chief medical officer of the manufacturer involved shall each certify in the notice under clause (i) that—

''(I) the information provided in the notice is complete and true; and

''(II) a copy of the notice has been provided to the Federal Trade Commission and to the State attorneys general.

''(iv) FEE.—

''(I) IN GENERAL.—If a notice submitted under clause (i) includes a difference that would, under section 506A, require the submission of a supplemental application if made as a change to the U.S. label drug, the person that submits the notice shall pay to the Secretary a fee in the same amount as would apply if the person were paying a fee pursuant to section 736(a)(1)(A)(ii). Fees collected by the Secretary under the preceding sentence are available only to the Secretary and are for the sole purpose of paying the costs of reviewing notices submitted under clause (i).

''(II) FEE AMOUNT FOR CERTAIN YEARS.—If no fee amount is in effect under section 736(a)(1)(A)(ii) for a fiscal year, then the amount paid by a person under subclause (I) shall—

''(aa) for the first fiscal year in which no fee amount under such section in effect, be equal to the fee amount under section 736(a)(1)(A)(ii) for the most recent fiscal year for which such section was in effect, adjusted in accordance with section 736(c); and

''(bb) for each subsequent fiscal year in which no fee amount under such section is effect, be equal to the applicable fee amount for the previous fiscal year, adjusted in accordance with section 736(c).

''(v) TIMING OF SUBMISSION OF NOTICES.—

''(I) PRIOR APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (C) applies shall be submitted to the Secretary not later than 120 days before the qualifying drug with the difference is introduced for commercial distribution in a permitted

country, unless the country requires that distribution of the qualifying drug with the difference begin less than 120 days after the country requires the difference.

''(II) OTHER APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (D) applies shall be submitted to the Secretary not later than the day on which the qualifying drug with the difference is introduced for commercial distribution in a permitted country.

''(III) OTHER NOTICES.—A notice under clause (i) to which subparagraph (E) applies shall be submitted to the Secretary on the date that the qualifying drug is first introduced for commercial distribution in a permitted country and annually thereafter.

''(vi) REVIEW BY SECRETARY.—

''(I) IN GENERAL.—In this paragraph, the difference in a qualifying drug that is submitted in a notice under clause (i) from the U.S. label drug shall be treated by the Secretary as if it were a manufacturing change to the U.S. label drug under section 506A.

''(II) STANDARD OF REVIEW.—Except as provided in subclause (III), the Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, using the safe and effective standard for approving or disapproving a manufacturing change under section 506A.

''(III) BIOEQUIVALENCE.—If the Secretary would approve the difference in a notice submitted under clause (i) using the safe and effective standard under section 506A and if the Secretary determines that the qualifying drug is not bioequivalent to the U.S. label drug, the Secretary shall—

''(aa) include in the labeling provided under paragraph (3) a prominent advisory that the qualifying drug is safe and effective but is not bioequivalent to the U.S. label drug if the Secretary determines that such an advisory is necessary for health care practitioners and patients to use the qualifying drug safely and effectively; or

''(bb) decline to approve the difference if the Secretary determines that the availability of both the qualifying drug and the U.S. label drug would pose a threat to the public health.

''(IV) REVIEW BY THE SECRETARY.—The Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, not later than 120 days after the date on which the notice is submitted.

''(V) ESTABLISHMENT INSPECTION.—If review of such difference would require an inspection of the establishment in which the qualifying drug is manufactured—

''(aa) such inspection by the Secretary shall be authorized; and

''(bb) the Secretary may rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(vii) PUBLICATION OF INFORMATION ON NOTICES.—

''(I) IN GENERAL.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall readily make available to the public a list of notices submitted under clause (i).

''(II) CONTENTS.—The list under subclause (I) shall include the date on which a notice is submitted and whether—

''(aa) a notice is under review;

''(bb) the Secretary has ordered that importation of the qualifying drug from a permitted country cease; or

''(cc) the importation of the drug is permitted under subsection (a).

''(III) UPDATE.—The Secretary shall promptly update the Internet website with any changes to the list.

''(C) NOTICE; DRUG DIFFERENCE REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under subsection (c) or (d)(3)(B)(i) of section 506A, require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) Promptly after the notice is submitted, the Secretary shall notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general that the notice has been submitted with respect to the qualifying drug involved.

''(ii) If the Secretary has not made a determination whether such a supplemental application regarding the U.S. label drug would be approved or disapproved by the date on which the qualifying drug involved is to be introduced for commercial distribution in a permitted country, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country not begin until the Secretary completes review of the notice; and

''(II) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the order.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease, or provide that an order under clause (ii), if any, remains in effect;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iv) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the Secretary shall—

''(I) vacate the order under clause (ii), if any;

''(II) consider the difference to be a variation provided for in the approved application for the U.S. label drug;

''(III) permit importation of the qualifying drug under subsection (a); and

''(IV) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(D) NOTICE; DRUG DIFFERENCE NOT REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under section 506A(d)(3)(B)(ii), not require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) During the period in which the notice is being reviewed by the Secretary, the authority under this subsection to import the qualifying drug involved continues in effect.

''(ii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the difference shall be considered to be a variation provided for in the approved application for the U.S. label drug.

''(E) NOTICE; DRUG DIFFERENCE NOT REQUIRING APPROVAL; NO DIFFERENCE.—In the case of a notice under subparagraph (B)(i) that includes a difference for which, under section 506A(d)(1)(A), a supplemental application would not be required for the difference to be made to the U.S. label drug, or that states that there is no difference, the Secretary—

''(i) shall consider such difference to be a variation provided for in the approved application for the U.S. label drug;

''(ii) may not order that the importation of the qualifying drug involved cease; and

''(iii) shall promptly notify registered exporters and registered importers.

''(F) DIFFERENCES IN ACTIVE INGREDIENT, ROUTE OF ADMINISTRATION, DOSAGE FORM, OR STRENGTH.—

''(i) IN GENERAL.—A person who manufactures a drug approved under section 505(b) shall submit an application under section 505(b) for approval of another drug that is manufactured for distribution in a permitted country by or for the person that manufactures the drug approved under section 505(b) if—

''(I) there is no qualifying drug in commercial distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries with the same active ingredient or ingredients, route of administration, dosage form, and strength as the drug approved under section 505(b); and

''(II) each active ingredient of the other drug is related to an active ingredient of the drug approved under section 505(b), as defined in clause (v).

''(ii) APPLICATION UNDER SECTION 505(b).—The application under section 505(b) required under clause (i) shall—

''(I) request approval of the other drug for the indication or indications for which the drug approved under section 505(b) is labeled;

''(II) include the information that the person submitted to the government of the permitted country for purposes of obtaining approval for commercial distribution of the other drug in that country, which if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation;

''(III) include a right of reference to the application for the drug approved under section 505(b); and

''(IV) include such additional information as the Secretary may require.

''(iii) TIMING OF SUBMISSION OF APPLICATION.—An application under section 505(b) required under clause (i) shall be submitted to the Secretary not later than the day on which the information referred to in clause (ii)(II) is submitted to the government of the permitted country.

''(iv) NOTICE OF DECISION ON APPLICATION.—The Secretary shall promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of a determination to approve or to disapprove an application under section 505(b) required under clause (i).

''(v) RELATED ACTIVE INGREDIENTS.—For purposes of clause (i)(II), 2 active ingredients are related if they are—

''(I) the same; or

''(II) different salts, esters, or complexes of the same moiety.

''(3) SECTION 502; LABELING.—

''(A) IMPORTATION BY REGISTERED IMPORTER.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered importer, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the qualifying drug bears—

''(I) a copy of the labeling approved for the U.S. label drug under section 505, without regard to whether the copy bears any trademark involved;

''(II) the name of the manufacturer and location of the manufacturer;

''(III) the lot number assigned by the manufacturer;

''(IV) the name, location, and registration number of the importer; and

''(V) the National Drug Code number assigned to the qualifying drug by the Secretary.

''(ii) REQUEST FOR COPY OF THE LABELING.—The Secretary shall provide such copy to the registered importer involved, upon request of the importer.

''(iii) REQUESTED LABELING.—The labeling provided by the Secretary under clause (ii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the qualifying drug;

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof;

''(III) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the qualifying drug is safe and effective but not bioequivalent to the U.S. label drug; and

''(IV) if the inactive ingredients of the qualifying drug are different from the inactive ingredients for the U.S. label drug, include—

''(aa) a prominent notice that the ingredients of the qualifying drug differ from the ingredients of the U.S. label drug and that the qualifying drug must be dispensed with an advisory to people with allergies about this difference and a list of ingredients; and

''(bb) a list of the ingredients of the qualifying drug as would be required under section 502(e).

''(B) IMPORTATION BY INDIVIDUAL.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered exporter to an individual, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the packaging and labeling of the qualifying drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and the labeling of the qualifying drug includes—

''(I) directions for use by the consumer;

''(II) the lot number assigned by the manufacturer;

''(III) the name and registration number of the exporter;

''(IV) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug;

''(V) if the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(aa) a prominent advisory that persons with an allergy should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(bb) a list of the ingredients of the drug as would be required under section 502(e); and

''(VI) a copy of any special labeling that would be required by the Secretary had the U.S. label drug been dispensed by a pharmacist in the United States, without regard to whether the special labeling bears any trademark involved.

''(ii) PACKAGING.—A qualifying drug offered for import to an individual by an exporter under this section that is packaged in a unit-of-use container (as those items are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(I) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(II) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the exporter will provide the drug in packaging that is compliant at no additional cost.

''(iii) REQUEST FOR COPY OF SPECIAL LABELING AND INGREDIENT LIST.—The Secretary shall provide to the registered exporter involved a copy of the special labeling, the advisory, and the ingredient list described under clause (i), upon request of the exporter.

''(iv) REQUESTED LABELING AND INGREDIENT LIST.—The labeling and ingredient list provided by the Secretary under clause (iii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the drug; and

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof.

''(4) SECTION 501; ADULTERATION.—A qualifying drug that is imported or offered for import under subsection (a) shall be considered to be in compliance with section 501 if the drug is in compliance with subsection (c).

''(5) STANDARDS FOR REFUSING ADMISSION.—A drug exported under subsection (a) from a registered exporter or imported by a registered importer may be refused admission into the United States if 1 or more of the following applies:

''(A) The drug is not a qualifying drug.

''(B) A notice for the drug required under paragraph (2)(B) has not been submitted to the Secretary.

''(C) The Secretary has ordered that importation of the drug from the permitted country cease under subparagraph (C) or (D) of paragraph (2).

''(D) The drug does not comply with paragraph (3) or (4).

''(E) The shipping container appears damaged in a way that may affect the strength, quality, or purity of the drug.

''(F) The Secretary becomes aware that—

''(i) the drug may be counterfeit;

''(ii) the drug may have been prepared, packed, or held under insanitary conditions; or

''(iii) the methods used in, or the facilities or controls used for, the manufacturing, processing, packing, or holding of the drug do not conform to good manufacturing practice.

''(G) The Secretary has obtained an injunction under section 302 that prohibits the distribution of the drug in interstate commerce.

''(H) The Secretary has under section 505(e) withdrawn approval of the drug.

''(I) The manufacturer of the drug has instituted a recall of the drug.

''(J) If the drug is imported or offered for import by a registered importer without submission of a notice in accordance with subsection (d)(4).

''(K) If the drug is imported or offered for import from a registered exporter to an individual and 1 or more of the following applies:

''(i) The shipping container for such drug does not bear the markings required under subsection (d)(2).

''(ii) The markings on the shipping container appear to be counterfeit.

''(iii) The shipping container or markings appear to have been tampered with.

''(h) EXPORTER LICENSURE IN PERMITTED COUNTRY.—A registration condition is that the exporter involved agrees that a qualifying drug will be exported to an individual only if the Secretary has verified that—

''(1) the exporter is authorized under the law of the permitted country in which the exporter is located to dispense prescription drugs; and

''(2) the exporter employs persons that are licensed under the law of the permitted country in which the exporter is located to dispense prescription drugs in sufficient number to dispense safely the drugs exported by the exporter to individuals, and the exporter assigns to those persons responsibility for dispensing such drugs to individuals.

''(i) INDIVIDUALS; CONDITIONS FOR IMPORTATION.—

''(1) IN GENERAL.—For purposes of subsection (a)(2)(B), the importation of a qualifying drug by an individual is in accordance with this subsection if the following conditions are met:

''(A) The drug is accompanied by a copy of a prescription for the drug, which prescription—

''(i) is valid under applicable Federal and State laws; and

''(ii) was issued by a practitioner who, under the law of a State of which the individual is a resident, or in which the individual receives care from the practitioner who issues the prescription, is authorized to administer prescription drugs.

''(B) The drug is accompanied by a copy of the documentation that was required under the law or regulations of the permitted country in which the exporter is located, as a condition of dispensing the drug to the individual.

''(C) The copies referred to in subparagraphs (A)(i) and (B) are marked in a manner sufficient—

''(i) to indicate that the prescription, and the equivalent document in the permitted country in which the exporter is located, have been filled; and

''(ii) to prevent a duplicative filling by another pharmacist.

''(D) The individual has provided to the registered exporter a complete list of all drugs used by the individual for review by the individuals who dispense the drug.

''(E) The quantity of the drug does not exceed a 90-day supply.

''(F) The drug is not an ineligible subpart H drug. For purposes of this section, a prescription drug is an 'ineligible subpart H drug' if the drug was approved by the Secretary under subpart H of part 314 of title 21, Code of Federal Regulations (relating to accelerated approval), with restrictions under section 520 of such part to assure safe use, and the Secretary has published in the Federal Register a notice that the Secretary has determined that good cause exists to prohibit the drug from being imported pursuant to this subsection.

''(2) NOTICE REGARDING DRUG REFUSED ADMISSION.—If a registered exporter ships a drug to an individual pursuant to subsection (a)(2)(B) and the drug is refused admission to the United States, a written notice shall be

sent to the individual and to the exporter that informs the individual and the exporter of such refusal and the reason for the refusal.

''(j) MAINTENANCE OF RECORDS AND SAMPLES.—

''(1) IN GENERAL.—A registration condition is that the importer or exporter involved shall—

''(A) maintain records required under this section for not less than 2 years; and

''(B) maintain samples of each lot of a qualifying drug required under this section for not more than 2 years.

''(2) PLACE OF RECORD MAINTENANCE.—The records described under paragraph (1) shall be maintained—

''(A) in the case of an importer, at the place of business of the importer at which the importer initially receives the qualifying drug after importation; or

''(B) in the case of an exporter, at the facility from which the exporter ships the qualifying drug to the United States.

''(k) DRUG RECALLS.—

''(1) MANUFACTURERS.—A person that manufactures a qualifying drug imported from a permitted country under this section shall promptly inform the Secretary—

''(A) if the drug is recalled or withdrawn from the market in a permitted country;

''(B) how the drug may be identified, including lot number; and

''(C) the reason for the recall or withdrawal.

''(2) SECRETARY.—With respect to each permitted country, the Secretary shall—

''(A) enter into an agreement with the government of the country to receive information about recalls and withdrawals of qualifying drugs in the country; or

''(B) monitor recalls and withdrawals of qualifying drugs in the country using any information that is available to the public in any media.

''(3) NOTICE.—The Secretary may notify, as appropriate, registered exporters, registered importers, wholesalers, pharmacies, or the public of a recall or withdrawal of a qualifying drug in a permitted country.

''(l) DRUG LABELING AND PACKAGING.—

''(1) IN GENERAL.—When a qualifying drug that is imported into the United States by an importer under subsection (a) is dispensed by a pharmacist to an individual, the pharmacist shall provide that the packaging and labeling of the drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and shall include with any other labeling provided to the individual the following:

''(A) The lot number assigned by the manufacturer.

''(B) The name and registration number of the importer.

''(C) If required under paragraph (2)(B)(vi)(III) of subsection (g), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug.

''(D) If the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(i) a prominent advisory that persons with allergies should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(ii) a list of the ingredients of the drug as would be required under section 502(e).

''(2) PACKAGING.—A qualifying drug that is packaged in a unit-of-use container (as those terms are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(A) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(B) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the pharmacist will provide the drug in packaging that is compliant at no additional cost.

''(m) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, this section does not authorize the importation into the United States of a qualifying drug donated or otherwise supplied for free or at nominal cost by the manufacturer of the drug to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country.

''(n) UNFAIR AND DISCRIMINATORY ACTS AND PRACTICES.—

''(1) IN GENERAL.—It is unlawful for a manufacturer, directly or indirectly (including by being a party to a licensing agreement or other agreement), to—

''(A) discriminate by charging a higher price for a prescription drug sold to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section than the price that is charged, inclusive of rebates or other incentives to the permitted country or other person, to another person that is in the same country and that does not export a qualifying drug into the United States under this section;

''(B) discriminate by charging a higher price for a prescription drug sold to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section than the price that is charged to another person in the United States that does not import a qualifying drug under this section, or that does not distribute, sell, or use such a drug;

''(C) discriminate by denying, restricting, or delaying supplies of a prescription drug to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(D) discriminate by publicly, privately, or otherwise refusing to do business with a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or with a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(E) knowingly fail to submit a notice under subsection (g)(2)(B)(i), knowingly fail to submit such a notice on or before the date specified in subsection (g)(2)(B)(v) or as otherwise required under paragraphs (3), (4), and (5) of section 10004(e) of the Pharmaceutical Market Access and Drug Safety Act of 2009, knowingly submit such a notice that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such a notice;

''(F) knowingly fail to submit an application required under subsection (g)(2)(F), knowingly fail to submit such an application on or before the date specified in subsection (g)(2)(F)(iii), knowingly submit such an application that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such an application;

''(G) cause there to be a difference (including a difference in active ingredient, route of administration, dosage form, strength, formulation, manufacturing establishment, manufacturing process, or person that manufactures the drug) between a prescription drug for distribution in the United States and the drug for distribution in a permitted country;

''(H) refuse to allow an inspection authorized under this section of an establishment that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country;

''(I) fail to conform to the methods used in, or the facilities used for, the manufacturing, processing, packing, or holding of a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country to good manufacturing practice under this Act;

''(J) become a party to a licensing agreement or other agreement related to a qualifying drug that fails to provide for compliance with all requirements of this section with respect to such drug;

''(K) enter into a contract that restricts, prohibits, or delays the importation of a qualifying drug under this section;

''(L) engage in any other action to restrict, prohibit, or delay the importation of a qualifying drug under this section; or

''(M) engage in any other action that the Federal Trade Commission determines to discriminate against a person that engages or attempts to engage in the importation of a qualifying drug under this section.

''(2) REFERRAL OF POTENTIAL VIOLATIONS.—The Secretary shall promptly refer to the Federal Trade Commission each potential violation of subparagraph (E), (F), (G), (H), or (I) of paragraph (1) that becomes known to the Secretary.

''(3) AFFIRMATIVE DEFENSE.—

''(A) DISCRIMINATION.—It shall be an affirmative defense to a charge that a manufacturer has discriminated under subparagraph (A), (B), (C), (D), or (M) of paragraph (1) that the higher price charged for a prescription drug sold to a person, the denial, restriction, or delay of supplies of a prescription drug to a person, the refusal to do business with a person, or other discriminatory activity against a person, is not based, in whole or in part, on—

''(i) the person exporting or importing a qualifying drug into the United States under this section; or

''(ii) the person distributing, selling, or using a qualifying drug imported into the United States under this section.

''(B) DRUG DIFFERENCES.—It shall be an affirmative defense to a charge that a manufacturer has caused there to be a difference described in subparagraph (G) of paragraph (1) that—

''(i) the difference was required by the country in which the drug is distributed;

''(ii) the Secretary has determined that the difference was necessary to improve the safety or effectiveness of the drug;

''(iii) the person manufacturing the drug for distribution in the United States has given notice to the Secretary under subsection (g)(2)(B)(i) that the drug for distribution in the United States is not different from a drug for distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries; or

''(iv) the difference was not caused, in whole or in part, for the purpose of restricting importation of the drug into the United States under this section.

''(4) EFFECT OF SUBSECTION.—

''(A) SALES IN OTHER COUNTRIES.—This subsection applies only to the sale or distribution of a prescription drug in a country if the manufacturer of the drug chooses to sell or distribute the drug in the country. Nothing in this subsection shall be construed to compel the manufacturer of a drug to distribute or sell the drug in a country.

''(B) DISCOUNTS TO INSURERS, HEALTH PLANS, PHARMACY BENEFIT MANAGERS, AND COVERED ENTITIES.—Nothing in this subsection shall be construed to—

''(i) prevent or restrict a manufacturer of a prescription drug from providing discounts to an insurer, health plan, pharmacy benefit manager in the United States, or covered entity in the drug discount program under section 340B of the Public Health Service Act (42 U.S.C. 256b) in return for inclusion of the drug on a formulary;

''(ii) require that such discounts be made available to other purchasers of the prescription drug; or

''(iii) prevent or restrict any other measures taken by an insurer, health plan, or pharmacy benefit manager to encourage consumption of such prescription drug.

''(C) CHARITABLE CONTRIBUTIONS.—Nothing in this subsection shall be construed to—

''(i) prevent a manufacturer from donating a prescription drug, or supplying a prescription drug at nominal cost, to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country; or

''(ii) apply to such donations or supplying of a prescription drug.

''(5) ENFORCEMENT.—

''(A) UNFAIR OR DECEPTIVE ACT OR PRACTICE.—A violation of this subsection shall be treated as a violation of a rule defining an unfair or deceptive act or practice prescribed under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

''(B) ACTIONS BY THE COMMISSION.—The Federal Trade Commission—

''(i) shall enforce this subsection in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section; and

''(ii) may seek monetary relief threefold the damages sustained, in addition to any other remedy available to the Federal Trade Commission under the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

''(6) ACTIONS BY STATES.—

''(A) IN GENERAL.—

''(i) CIVIL ACTIONS.—In any case in which the attorney general of a State has reason to believe that an interest of the residents of that State have been adversely affected by any manufacturer that violates paragraph (1), the attorney general of a State may bring a civil action on behalf of the residents of the State, and persons doing business in the State, in a district court of the United States of appropriate jurisdiction to—

''(I) enjoin that practice;

''(II) enforce compliance with this subsection;

''(III) obtain damages, restitution, or other compensation on behalf of residents of the State and persons doing business in the State, including threefold the damages; or

''(IV) obtain such other relief as the court may consider to be appropriate.

''(ii) NOTICE.—

''(I) IN GENERAL.—Before filing an action under clause (i), the attorney general of the State involved shall provide to the Federal Trade Commission—

''(aa) written notice of that action; and

''(bb) a copy of the complaint for that action.

''(II) EXEMPTION.—Subclause (I) shall not apply with respect to the filing of an action by an attorney general of a State under this paragraph, if the attorney general determines that it is not feasible to provide the notice described in that subclause before filing of the action. In such case, the attorney general of a State shall provide notice and a copy of the complaint to the Federal Trade Commission at the same time as the attorney general files the action.

''(B) INTERVENTION.—

''(i) IN GENERAL.—On receiving notice under subparagraph (A)(ii), the Federal Trade Commission shall have the right to intervene in the action that is the subject of the notice.

''(ii) EFFECT OF INTERVENTION.—If the Federal Trade Commission intervenes in an action under subparagraph (A), it shall have the right—

''(I) to be heard with respect to any matter that arises in that action; and

''(II) to file a petition for appeal.

''(C) CONSTRUCTION.—For purposes of bringing any civil action under subparagraph (A), nothing in this subsection shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State to—

''(i) conduct investigations;

''(ii) administer oaths or affirmations; or

''(iii) compel the attendance of witnesses or the production of documentary and other evidence.

''(D) ACTIONS BY THE COMMISSION.—In any case in which an action is instituted by or on behalf of the Federal Trade Commission for a violation of paragraph (1), a State may not, during the pendency of that action, institute an action under subparagraph (A) for the same violation against any defendant named in the complaint in that action.

''(E) VENUE.—Any action brought under subparagraph (A) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

''(F) SERVICE OF PROCESS.—In an action brought under subparagraph (A), process may be served in any district in which the defendant—

''(i) is an inhabitant; or

''(ii) may be found.

''(G) MEASUREMENT OF DAMAGES.—In any action under this paragraph to enforce a cause of action under this subsection in which there has been a determination that a defendant has violated a provision of this subsection, damages may be proved and assessed in the aggregate by statistical or sampling methods, by the computation of illegal overcharges or by such other reasonable system of estimating aggregate damages as the court in its discretion may permit without the necessity of separately proving the individual claim of, or amount of damage to, persons on whose behalf the suit was brought.

''(H) EXCLUSION ON DUPLICATIVE RELIEF.—The district court shall exclude from the amount of monetary relief awarded in an action under this paragraph brought by the attorney general of a State any amount of monetary relief which duplicates amounts which have been awarded for the same injury.

''(7) EFFECT ON ANTITRUST LAWS.—Nothing in this subsection shall be construed to modify, impair, or supersede the operation of the antitrust laws. For the purpose of this subsection, the term 'antitrust laws' has the meaning given it in the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

''(8) MANUFACTURER.—In this subsection, the term 'manufacturer' means any entity, including any affiliate or licensee of that entity, that is engaged in—

''(A) the production, preparation, propagation, compounding, conversion, or processing of a prescription drug, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or

''(B) the packaging, repackaging, labeling, relabeling, or distribution of a prescription drug.''.

(b) PROHIBITED ACTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301 (21 U.S.C. 331), by striking paragraph (aa) and inserting the following:

''(aa)(1) The sale or trade by a pharmacist, or by a business organization of which the pharmacist is a part, of a qualifying drug that under section 804(a)(2)(A) was imported by the pharmacist, other than—

''(A) a sale at retail made pursuant to dispensing the drug to a customer of the pharmacist or organization; or

''(B) a sale or trade of the drug to a pharmacy or a wholesaler registered to import drugs under section 804.

''(2) The sale or trade by an individual of a qualifying drug that under section 804(a)(2)(B) was imported by the individual.

''(3) The making of a materially false, fictitious, or fraudulent statement or representation, or a material omission, in a notice under clause (i) of section 804(g)(2)(B) or in an application required under section 804(g)(2)(F), or the failure to submit such a notice or application.

''(4) The importation of a drug in violation of a registration condition or other requirement under section 804, the falsification of any record required to be maintained, or provided to the Secretary, under such section, or the violation of any registration condition or other requirement under such section.''; and

(2) in section 303(a) (21 U.S.C. 333(a)), by striking paragraph (6) and inserting the following:

''(6) Notwithstanding subsection (a), any person that knowingly violates section 301(i)(2) or (3) or section 301(aa)(4) shall be imprisoned not more than 10 years, or fined in accordance with title 18, United States Code, or both.''.

(c) AMENDMENT OF CERTAIN PROVISIONS.—

(1) IN GENERAL.—Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by striking subsection (g) and inserting the following:

''(g) With respect to a prescription drug that is imported or offered for import into the United States by an individual who is not in the business of such importation, that is not shipped by a registered exporter under section 804, and that is refused admission under subsection (a), the Secretary shall notify the individual that—

''(1) the drug has been refused admission because the drug was not a lawful import under section 804;

''(2) the drug is not otherwise subject to a waiver of the requirements of subsection (a);

''(3) the individual may under section 804 lawfully import certain prescription drugs from exporters registered with the Secretary under section 804; and

''(4) the individual can find information about such importation, including a list of registered exporters, on the Internet website of the Food and Drug Administration or through a toll-free telephone number required under section 804.''.

(2) ESTABLISHMENT REGISTRATION.—Section 510(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(i)) is amended in paragraph (1) by inserting after ''import into the United States'' the following: '', including a drug that is, or may be, imported or offered for import into the United States under section 804,''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 90 days after the date of enactment of this Act.

(d) EXHAUSTION.—

(1) IN GENERAL.—Section 271 of title 35, United States Code, is amended—

(A) by redesignating subsections (h) and (i) as (i) and (j), respectively; and

(B) by inserting after subsection (g) the following:

''(h) It shall not be an act of infringement to use, offer to sell, or sell within the United States or to import into the United States any patented invention under section 804 of the Federal Food, Drug, and Cosmetic Act that was first sold abroad by or under authority of the owner or licensee of such patent.''.

(2) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the ability of a patent owner or licensee to enforce their patent, subject to such amendment.

(e) EFFECT OF SECTION 804.—

(1) IN GENERAL.—Section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall permit the importation of qualifying drugs (as defined in such section 804) into the United States without regard to the status of the issuance of implementing regulations—

(A) from exporters registered under such section 804 on the date that is 90 days after the date of enactment of this Act; and

(B) from permitted countries, as defined in such section 804, by importers registered under such section 804 on the date that is 1 year after the date of enactment of this Act.

(2) REVIEW OF REGISTRATION BY CERTAIN EXPORTERS.—

(A) REVIEW PRIORITY.—In the review of registrations submitted under subsection (b) of such section 804, registrations submitted by entities in Canada that are significant exporters of prescription drugs to individuals in the United States as of the date of enactment of this Act will have priority during the 90 day period that begins on such date of enactment.

(B) PERIOD FOR REVIEW.—During such 90-day period, the reference in subsection (b)(2)(A) of such section 804 to 90 days (relating to approval or disapproval of registrations) is, as applied to such entities, deemed to be 30 days.

(C) LIMITATION.—That an exporter in Canada exports, or has exported, prescription drugs to individuals in the United States on or before the date that is 90 days after the date of enactment of this Act shall not serve as a basis, in whole or in part, for disapproving a registration under such section 804 from the exporter.

(D) FIRST YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') may limit the number of registered exporters under such section 804 to not less than 50, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(E) SECOND YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 100, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(F) FURTHER LIMIT ON NUMBER OF EXPORTERS.—During any 1-year period beginning on a date that is 2 or more years after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 25 more than the number of such exporters during the previous 1-year period, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(3) LIMITS ON NUMBER OF IMPORTERS.—

(A) FIRST YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 100 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs imported into the United States.

(B) SECOND YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 2 years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 200 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs into the United States.

(C) FURTHER LIMIT ON NUMBER OF IMPORTERS.—During any 1-year period beginning on a date that is 3 or more years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 50 more (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups) than the number of such importers during the previous 1-year period, so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs to the United States.

(4) NOTICES FOR DRUGS FOR IMPORT FROM CANADA.—The notice with respect to a qualifying drug introduced for commercial distribution in Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 30 days after the date of enactment of this Act if—

(A) the U.S. label drug (as defined in such section 804) for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period most recently completed before the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(5) NOTICE FOR DRUGS FOR IMPORT FROM OTHER COUNTRIES.—The notice with respect to a qualifying drug introduced for commercial distribution in a permitted country other than Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 180 days after the date of enactment of this Act if—

(A) the U.S. label drug for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period that is first completed on the date that is 120 days after the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(6) NOTICE FOR OTHER DRUGS FOR IMPORT.—

(A) GUIDANCE ON SUBMISSION DATES.—The Secretary shall by guidance establish a series of submission dates for the notices under subsection (g)(2)(B)(i) of such section 804 with respect to qualifying drugs introduced for commercial distribution as of the date of enactment of this Act and that are not required to be submitted under paragraph (4) or (5).

(B) CONSISTENT AND EFFICIENT USE OF RESOURCES.—The Secretary shall establish the dates described under subparagraph (A) so that such notices described under subparagraph (A) are submitted and reviewed at a rate that allows consistent and efficient use of the resources and staff available to the Secretary for such reviews. The Secretary may condition the requirement to submit such a notice, and the review of such a notice, on the submission by a registered exporter or a registered importer to the Secretary of a notice that such exporter or importer intends to import such qualifying drug to the United States under such section 804.

(C) PRIORITY FOR DRUGS WITH HIGHER SALES.—The Secretary shall establish the dates described under subparagraph (A) so that the Secretary reviews the notices described under such subparagraph with respect to qualifying drugs with higher dollar volume of sales in the United States before the notices with respect to drugs with lower sales in the United States.

(7) NOTICES FOR DRUGS APPROVED AFTER EFFECTIVE DATE.—The notice required under subsection (g)(2)(B)(i) of such section 804 for a qualifying drug first introduced for commercial distribution in a permitted country (as defined in such section 804) after the date of enactment of this Act shall be submitted to and reviewed by the Secretary as provided under subsection (g)(2)(B) of such section 804, without regard to paragraph (4), (5), or (6).

(8) REPORT.—Beginning with the first full fiscal year after the date of enactment of this Act, not later than 90 days after the end of each fiscal year during which the Secretary reviews a notice referred to in paragraph (4), (5), or (6), the Secretary shall submit a report to Congress concerning the progress of the Food and Drug Administration in reviewing the notices referred to in paragraphs (4), (5), and (6).

(9) USER FEES.—

(A) EXPORTERS.—When establishing an aggregate total of fees to be collected from exporters under subsection (f)(2) of such section 804, the Secretary shall, under subsection (f)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered exporters during the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365.

(B) IMPORTERS.—When establishing an aggregate total of fees to be collected from importers under subsection (e)(2) of such section 804, the Secretary shall, under subsection (e)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered importers during—

(i) the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365; and

(ii) the second fiscal year in which this title is in effect to be $3,000,000,000.

(C) SECOND YEAR ADJUSTMENT.—

(i) REPORTS.—Not later than February 20 of the second fiscal year in which this title is in effect, registered importers shall report to the Secretary the total price and the total

volume of drugs imported to the United States by the importer during the 4-month period from October 1 through January 31 of such fiscal year.

(ii) REESTIMATE.—Notwithstanding subsection (e)(3)(C)(ii) of such section 804 or subparagraph (B), the Secretary shall reestimate the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during the second fiscal year in which this title is in effect. Such reestimate shall be equal to—

(I) the total price of qualifying drugs imported by each importer as reported under clause (i); multiplied by

(II) 3.

(iii) ADJUSTMENT.—The Secretary shall adjust the fee due on April 1 of the second fiscal year in which this title is in effect, from each importer so that the aggregate total of fees collected under subsection (e)(2) for such fiscal year does not exceed the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during such fiscal year as reestimated under clause (ii).

(D) FAILURE TO PAY FEES.—Notwithstanding any other provision of this section, the Secretary may prohibit a registered importer or exporter that is required to pay user fees under subsection (e) or (f) of such section 804 and that fails to pay such fees within 30 days after the date on which it is due, from importing or offering for importation a qualifying drug under such section 804 until such fee is paid.

(E) ANNUAL REPORT.—

(i) FOOD AND DRUG ADMINISTRATION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e), (f), or (g)(2)(B)(iv) of such section 804, the Secretary shall prepare and submit to the House of Representatives and the Senate a report on the implementation of the authority for such fees during such fiscal year and the use, by the Food and Drug Administration, of the fees collected for the fiscal year for which the report is made and credited to the Food and Drug Administration.

(ii) CUSTOMS AND BORDER PROTECTION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e) or (f) of such section 804, the Secretary of Homeland Security, in consultation with the Secretary of the Treasury, shall prepare and submit to the House of Representatives and the Senate a report on the use, by the Bureau of Customs and Border Protection, of the fees, if any, transferred by the Secretary to the Bureau of Customs and Border Protection for the fiscal year for which the report is made.

(10) SPECIAL RULE REGARDING IMPORTATION BY INDIVIDUALS.—

(A) IN GENERAL.—Notwithstanding any provision of this title (or an amendment made by this title), the Secretary shall expedite the designation of any additional permitted countries from which an individual may import a qualifying drug into the United States under such section 804 if any action implemented by the Government of Canada has the effect of limiting or prohibiting the importation of qualifying drugs into the United States from Canada.

(B) TIMING AND CRITERIA.—The Secretary shall designate such additional permitted countries under subparagraph (A)—

(i) not later than 6 months after the date of the action by the Government of Canada described under such subparagraph; and

(ii) using the criteria described under subsection (a)(4)(D)(i)(II) of such section 804.

(f) IMPLEMENTATION OF SECTION 804.—

(1) INTERIM RULE.—The Secretary may promulgate an interim rule for implementing section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a) of this section.

(2) NO NOTICE OF PROPOSED RULEMAKING.—The interim rule described under paragraph (1) may be developed and promulgated by the Secretary without providing general notice of proposed rulemaking.

(3) FINAL RULE.—Not later than 1 year after the date on which the Secretary promulgates an interim rule under paragraph (1), the Secretary shall, in accordance with procedures under section 553 of title 5, United States Code, promulgate a final rule for implementing such section 804, which may incorporate by reference provisions of the interim rule provided for under paragraph (1), to the extent that such provisions are not modified.

(g) CONSUMER EDUCATION.—The Secretary shall carry out activities that educate consumers—

(1) with regard to the availability of qualifying drugs for import for personal use from an exporter registered with and approved by the Food and Drug Administration under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by this section, including information on how to verify whether an exporter is registered and approved by use of the Internet website of the Food and Drug Administration and the toll-free telephone number required by this title;

(2) that drugs that consumers attempt to import from an exporter that is not registered with and approved by the Food and Drug Administration can be seized by the United States Customs Service and destroyed, and that such drugs may be counterfeit, unapproved, unsafe, or ineffective;

(3) with regard to the suspension and termination of any registration of a registered importer or exporter under such section 804; and

(4) with regard to the availability at domestic retail pharmacies of qualifying drugs imported under such section 804 by domestic wholesalers and pharmacies registered with and approved by the Food and Drug Administration.

(h) EFFECT ON ADMINISTRATION PRACTICES.—Notwithstanding any provision of this title (and the amendments made by this title), the practices and policies of the Food and Drug Administration and Bureau of Customs and Border Protection, in effect on January 1, 2004, with respect to the importation of prescription drugs into the United States by an individual, on the person of such individual, for personal use, shall remain in effect.

(i) REPORT TO CONGRESS.—The Federal Trade Commission shall, on an annual basis, submit to Congress a report that describes any action taken during the period for which the report is being prepared to enforce the provisions of section 804(n) of the Federal Food, Drug, and Cosmetic Act (as added by this title), including any pending investigations or civil actions under such section.

SEC. 10005. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION INTO UNITED STATES.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10004, is further amended by adding at the end the following section:

"SEC. 805. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION.

"(a) IN GENERAL.—The Secretary of Homeland Security shall deliver to the Secretary a shipment of drugs that is imported or offered for import into the United States if—

"(1) the shipment has a declared value of less than $10,000; and

"(2)(A) the shipping container for such drugs does not bear the markings required under section 804(d)(2); or

"(B) the Secretary has requested delivery of such shipment of drugs.

"(b) NO BOND OR EXPORT.—Section 801(b) does not authorize the delivery to the owner or consignee of drugs delivered to the Secretary under subsection (a) pursuant to the execution of a bond, and such drugs may not be exported.

"(c) DESTRUCTION OF VIOLATIVE SHIPMENT.—The Secretary shall destroy a shipment of drugs delivered by the Secretary of Homeland Security to the Secretary under subsection (a) if—

"(1) in the case of drugs that are imported or offered for import from a registered exporter under section 804, the drugs are in violation of any standard described in section 804(g)(5); or

"(2) in the case of drugs that are not imported or offered for import from a registered exporter under section 804, the drugs are in violation of a standard referred to in section 801(a) or 801(d)(1).

"(d) CERTAIN PROCEDURES.—

"(1) IN GENERAL.—The delivery and destruction of drugs under this section may be carried out without notice to the importer, owner, or consignee of the drugs except as required by section 801(g) or section 804(i)(2). The issuance of receipts for the drugs, and recordkeeping activities regarding the drugs, may be carried out on a summary basis.

"(2) OBJECTIVE OF PROCEDURES.—Procedures promulgated under paragraph (1) shall be designed toward the objective of ensuring that, with respect to efficiently utilizing Federal resources available for carrying out this section, a substantial majority of shipments of drugs subject to described in subsection (c) are identified and destroyed.

"(e) EVIDENCE EXCEPTION.—Drugs may not be destroyed under subsection (c) to the extent that the Attorney General of the United States determines that the drugs should be preserved as evidence or potential evidence with respect to an offense against the United States.

"(f) RULE OF CONSTRUCTION.—This section may not be construed as having any legal effect on applicable law with respect to a shipment of drugs that is imported or offered for import into the United States and has a declared value equal to or greater than $10,000.".

(b) PROCEDURES.—Procedures for carrying out section 805 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall be established not later than 90 days after the date of the enactment of this Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 90 days after the date of enactment of this Act.

SEC. 10006. WHOLESALE DISTRIBUTION OF DRUGS; STATEMENTS REGARDING PRIOR SALE, PURCHASE, OR TRADE.

(a) STRIKING OF EXEMPTIONS; APPLICABILITY TO REGISTERED EXPORTERS.—Section 503(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(e)) is amended—

(1) in paragraph (1)—

(A) by striking "and who is not the manufacturer or an authorized distributor of record of such drug";

(B) by striking "to an authorized distributor of record or"; and

(C) by striking subparagraph (B) and inserting the following:

"(B) The fact that a drug subject to subsection (b) is exported from the United States does not with respect to such drug exempt any person that is engaged in the business of the wholesale distribution of the drug from providing the statement described in subparagraph (A) to the person that receives the drug pursuant to the export of the drug.

''(C)(i) The Secretary shall by regulation establish requirements that supersede subparagraph (A) (referred to in this subparagraph as 'alternative requirements') to identify the chain of custody of a drug subject to subsection (b) from the manufacturer of the drug throughout the wholesale distribution of the drug to a pharmacist who intends to sell the drug at retail if the Secretary determines that the alternative requirements, which may include standardized anti-counterfeiting or track-and-trace technologies, will identify such chain of custody or the identity of the discrete package of the drug from which the drug is dispensed with equal or greater certainty to the requirements of subparagraph (A), and that the alternative requirements are economically and technically feasible.

''(ii) When the Secretary promulgates a final rule to establish such alternative requirements, the final rule in addition shall, with respect to the registration condition established in clause (i) of section 804(c)(3)(B), establish a condition equivalent to the alternative requirements, and such equivalent condition may be met in lieu of the registration condition established in such clause (i).'';

(2) in paragraph (2)(A), by adding at the end the following: ''The preceding sentence may not be construed as having any applicability with respect to a registered exporter under section 804.''; and

(3) in paragraph (3), by striking ''and subsection (d)—'' in the matter preceding subparagraph (A) and all that follows through ''the term 'wholesale distribution' means'' in subparagraph (B) and inserting the following: ''and subsection (d), the term 'wholesale distribution' means''.

(b) CONFORMING AMENDMENT.—Section 503(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(d)) is amended by adding at the end the following:

''(4) Each manufacturer of a drug subject to subsection (b) shall maintain at its corporate offices a current list of the authorized distributors of record of such drug.

''(5) For purposes of this subsection, the term 'authorized distributors of record' means those distributors with whom a manufacturer has established an ongoing relationship to distribute such manufacturer's products.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on January 1, 2012.

(2) DRUGS IMPORTED BY REGISTERED IMPORTERS UNDER SECTION 804.—Notwithstanding paragraph (1), the amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on the date that is 90 days after the date of enactment of this Act with respect to qualifying drugs imported under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by section 10004.

(3) EFFECT WITH RESPECT TO REGISTERED EXPORTERS.—The amendment made by subsection (a)(2) shall take effect on the date that is 90 days after the date of enactment of this Act.

(4) ALTERNATIVE REQUIREMENTS.—The Secretary shall issue regulations to establish the alternative requirements, referred to in the amendment made by subsection (a)(1), that take effect not later than January 1, 2012.

(5) INTERMEDIATE REQUIREMENTS.—The Secretary shall by regulation require the use of standardized anti-counterfeiting or track-and-trace technologies on prescription drugs at the case and pallet level effective not later than 1 year after the date of enactment of this Act.

(6) ADDITIONAL REQUIREMENTS.—

(A) IN GENERAL.—Notwithstanding any other provision of this section, the Secretary shall, not later than 18 months after the date of enactment of this Act, require that the packaging of any prescription drug incorporates—

(i) a standardized numerical identifier unique to each package of such drug, applied at the point of manufacturing and repackaging (in which case the numerical identifier shall be linked to the numerical identifier applied at the point of manufacturing); and

(ii)(I) overt optically variable counterfeit-resistant technologies that—

(aa) are visible to the naked eye, providing for visual identification of product authenticity without the need for readers, microscopes, lighting devices, or scanners;

(bb) are similar to that used by the Bureau of Engraving and Printing to secure United States currency;

(cc) are manufactured and distributed in a highly secure, tightly controlled environment; and

(dd) incorporate additional layers of nonvisible convert security features up to and including forensic capability, as described in subparagraph (B); or

(II) technologies that have a function of security comparable to that described in subclause (I), as determined by the Secretary.

(B) STANDARDS FOR PACKAGING.—For the purpose of making it more difficult to counterfeit the packaging of drugs subject to this paragraph, the manufacturers of such drugs shall incorporate the technologies described in subparagraph (A) into at least 1 additional element of the physical packaging of the drugs, including blister packs, shrink wrap, package labels, package seals, bottles, and boxes.

SEC. 10007. INTERNET SALES OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503B the following:

''SEC. 503C. INTERNET SALES OF PRESCRIPTION DRUGS.

''(a) REQUIREMENTS REGARDING INFORMATION ON INTERNET SITE.—

''(1) IN GENERAL.—A person may not dispense a prescription drug pursuant to a sale of the drug by such person if—

''(A) the purchaser of the drug submitted the purchase order for the drug, or conducted any other part of the sales transaction for the drug, through an Internet site;

''(B) the person dispenses the drug to the purchaser by mailing or shipping the drug to the purchaser; and

''(C) such site, or any other Internet site used by such person for purposes of sales of a prescription drug, fails to meet each of the requirements specified in paragraph (2), other than a site or pages on a site that—

''(i) are not intended to be accessed by purchasers or prospective purchasers; or

''(ii) provide an Internet information location tool within the meaning of section 231(e)(5) of the Communications Act of 1934 (47 U.S.C. 231(e)(5)).

''(2) REQUIREMENTS.—With respect to an Internet site, the requirements referred to in subparagraph (C) of paragraph (1) for a person to whom such paragraph applies are as follows:

''(A) Each page of the site shall include either the following information or a link to a page that provides the following information:

''(i) The name of such person.

''(ii) Each State in which the person is authorized by law to dispense prescription drugs.

''(iii) The address and telephone number of each place of business of the person with respect to sales of prescription drugs through the Internet, other than a place of business that does not mail or ship prescription drugs to purchasers.

''(iv) The name of each individual who serves as a pharmacist for prescription drugs that are mailed or shipped pursuant to the site, and each State in which the individual is authorized by law to dispense prescription drugs.

''(v) If the person provides for medical consultations through the site for purposes of providing prescriptions, the name of each individual who provides such consultations; each State in which the individual is licensed or otherwise authorized by law to provide such consultations or practice medicine; and the type or types of health professions for which the individual holds such licenses or other authorizations.

''(B) A link to which paragraph (1) applies shall be displayed in a clear and prominent place and manner, and shall include in the caption for the link the words 'licensing and contact information'.

''(b) INTERNET SALES WITHOUT APPROPRIATE MEDICAL RELATIONSHIPS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a person may not dispense a prescription drug, or sell such a drug, if—

''(A) for purposes of such dispensing or sale, the purchaser communicated with the person through the Internet;

''(B) the patient for whom the drug was dispensed or purchased did not, when such communications began, have a prescription for the drug that is valid in the United States;

''(C) pursuant to such communications, the person provided for the involvement of a practitioner, or an individual represented by the person as a practitioner, and the practitioner or such individual issued a prescription for the drug that was purchased;

''(D) the person knew, or had reason to know, that the practitioner or the individual referred to in subparagraph (C) did not, when issuing the prescription, have a qualifying medical relationship with the patient; and

''(E) the person received payment for the dispensing or sale of the drug.

For purposes of subparagraph (E), payment is received if money or other valuable consideration is received.

''(2) EXCEPTIONS.—Paragraph (1) does not apply to—

''(A) the dispensing or selling of a prescription drug pursuant to telemedicine practices sponsored by—

''(i) a hospital that has in effect a provider agreement under title XVIII of the Social Security Act (relating to the Medicare program); or

''(ii) a group practice that has not fewer than 100 physicians who have in effect provider agreements under such title; or

''(B) the dispensing or selling of a prescription drug pursuant to practices that promote the public health, as determined by the Secretary by regulation.

''(3) QUALIFYING MEDICAL RELATIONSHIP.—

''(A) IN GENERAL.—With respect to issuing a prescription for a drug for a patient, a practitioner has a qualifying medical relationship with the patient for purposes of this section if—

''(i) at least one in-person medical evaluation of the patient has been conducted by the practitioner; or

''(ii) the practitioner conducts a medical evaluation of the patient as a covering practitioner.

''(B) IN-PERSON MEDICAL EVALUATION.—A medical evaluation by a practitioner is an in-person medical evaluation for purposes of this section if the practitioner is in the physical presence of the patient as part of conducting the evaluation, without regard to

whether portions of the evaluation are conducted by other health professionals.

''(C) COVERING PRACTITIONER.—With respect to a patient, a practitioner is a covering practitioner for purposes of this section if the practitioner conducts a medical evaluation of the patient at the request of a practitioner who has conducted at least one in-person medical evaluation of the patient and is temporarily unavailable to conduct the evaluation of the patient. A practitioner is a covering practitioner without regard to whether the practitioner has conducted any in-person medical evaluation of the patient involved.

''(4) RULES OF CONSTRUCTION.—

''(A) INDIVIDUALS REPRESENTED AS PRACTITIONERS.—A person who is not a practitioner (as defined in subsection (e)(1)) lacks legal capacity under this section to have a qualifying medical relationship with any patient.

''(B) STANDARD PRACTICE OF PHARMACY.—Paragraph (1) may not be construed as prohibiting any conduct that is a standard practice in the practice of pharmacy.

''(C) APPLICABILITY OF REQUIREMENTS.—Paragraph (3) may not be construed as having any applicability beyond this section, and does not affect any State law, or interpretation of State law, concerning the practice of medicine.

''(c) ACTIONS BY STATES.—

''(1) IN GENERAL.—Whenever an attorney general of any State has reason to believe that the interests of the residents of that State have been or are being threatened or adversely affected because any person has engaged or is engaging in a pattern or practice that violates section 301(l), the State may bring a civil action on behalf of its residents in an appropriate district court of the United States to enjoin such practice, to enforce compliance with such section (including a nationwide injunction), to obtain damages, restitution, or other compensation on behalf of residents of such State, to obtain reasonable attorneys fees and costs if the State prevails in the civil action, or to obtain such further and other relief as the court may deem appropriate.

''(2) NOTICE.—The State shall serve prior written notice of any civil action under paragraph (1) or (5)(B) upon the Secretary and provide the Secretary with a copy of its complaint, except that if it is not feasible for the State to provide such prior notice, the State shall serve such notice immediately upon instituting such action. Upon receiving a notice respecting a civil action, the Secretary shall have the right—

''(A) to intervene in such action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(3) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this chapter shall prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses or the production of documentary and other evidence.

''(4) VENUE; SERVICE OF PROCESS.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such an action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

''(5) ACTIONS BY OTHER STATE OFFICIALS.—

''(A) Nothing contained in this section shall prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any civil or criminal statute of such State.

''(B) In addition to actions brought by an attorney general of a State under paragraph (1), such an action may be brought by officers of such State who are authorized by the State to bring actions in such State on behalf of its residents.

''(d) EFFECT OF SECTION.—This section shall not apply to a person that is a registered exporter under section 804.

''(e) GENERAL DEFINITIONS.—For purposes of this section:

''(1) The term 'practitioner' means a practitioner referred to in section 503(b)(1) with respect to issuing a written or oral prescription.

''(2) The term 'prescription drug' means a drug that is described in section 503(b)(1).

''(3) The term 'qualifying medical relationship', with respect to a practitioner and a patient, has the meaning indicated for such term in subsection (b).

''(f) INTERNET-RELATED DEFINITIONS.—

''(1) IN GENERAL.—For purposes of this section:

''(A) The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected world-wide network of networks that employ the transmission control protocol/internet protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio.

''(B) The term 'link', with respect to the Internet, means one or more letters, words, numbers, symbols, or graphic items that appear on a page of an Internet site for the purpose of serving, when activated, as a method for executing an electronic command—

''(i) to move from viewing one portion of a page on such site to another portion of the page;

''(ii) to move from viewing one page on such site to another page on such site; or

''(iii) to move from viewing a page on one Internet site to a page on another Internet site.

''(C) The term 'page', with respect to the Internet, means a document or other file accessed at an Internet site.

''(D)(i) The terms 'site' and 'address', with respect to the Internet, mean a specific location on the Internet that is determined by Internet Protocol numbers. Such term includes the domain name, if any.

''(ii) The term 'domain name' means a method of representing an Internet address without direct reference to the Internet Protocol numbers for the address, including methods that use designations such as '.com', '.edu', '.gov', '.net', or '.org'.

''(iii) The term 'Internet Protocol numbers' includes any successor protocol for determining a specific location on the Internet.

''(2) AUTHORITY OF SECRETARY.—The Secretary may by regulation modify any definition under paragraph (1) to take into account changes in technology.

''(g) INTERACTIVE COMPUTER SERVICE; ADVERTISING.—No provider of an interactive computer service, as defined in section 230(f)(2) of the Communications Act of 1934 (47 U.S.C. 230(f)(2)), or of advertising services shall be liable under this section for dispensing or selling prescription drugs in violation of this section on account of another person's selling or dispensing such drugs, provided that the provider of the interactive computer service or of advertising services does not own or exercise corporate control over such person.

''(h) NO EFFECT ON OTHER REQUIREMENTS; COORDINATION.—The requirements of this section are in addition to, and do not supersede, any requirements under the Controlled Substances Act or the Controlled Substances Import and Export Act (or any regulation promulgated under either such Act) regarding Internet pharmacies and controlled substances. In promulgating regulations to carry out this section, the Secretary shall coordinate with the Attorney General to ensure that such regulations do not duplicate or conflict with the requirements described in the previous sentence, and that such regulations and requirements coordinate to the extent practicable.''.

(b) INCLUSION AS PROHIBITED ACT.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after paragraph (k) the following:

''(l) The dispensing or selling of a prescription drug in violation of section 503C.''.

(c) INTERNET SALES OF PRESCRIPTION DRUGS; CONSIDERATION BY SECRETARY OF PRACTICES AND PROCEDURES FOR CERTIFICATION OF LEGITIMATE BUSINESSES.—In carrying out section 503C of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall take into consideration the practices and procedures of public or private entities that certify that businesses selling prescription drugs through Internet sites are legitimate businesses, including practices and procedures regarding disclosure formats and verification programs.

(d) REPORTS REGARDING INTERNET-RELATED VIOLATIONS OF FEDERAL AND STATE LAWS ON DISPENSING OF DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, pursuant to the submission of an application meeting the criteria of the Secretary, make an award of a grant or contract to the National Clearinghouse on Internet Prescribing (operated by the Federation of State Medical Boards) for the purpose of—

(A) identifying Internet sites that appear to be in violation of Federal or State laws concerning the dispensing of drugs;

(B) reporting such sites to State medical licensing boards and State pharmacy licensing boards, and to the Attorney General and the Secretary, for further investigation; and

(C) submitting, for each fiscal year for which the award under this subsection is made, a report to the Secretary describing investigations undertaken with respect to violations described in subparagraph (A).

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there is authorized to be appropriated $100,000 for each of the first 3 fiscal years in which this section is in effect.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect 90 days after the date of enactment of this Act, without regard to whether a final rule to implement such amendments has been promulgated by the Secretary of Health and Human Services under section 701(a) of the Federal Food, Drug, and Cosmetic Act. The preceding sentence may not be construed as affecting the authority of such Secretary to promulgate such a final rule.

SEC. 10008. PROHIBITING PAYMENTS TO UNREGISTERED FOREIGN PHARMACIES.

(a) IN GENERAL.—Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) RESTRICTED TRANSACTIONS.—

''(1) IN GENERAL.—The introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system is prohibited.

''(2) PAYMENT SYSTEM.—

''(A) IN GENERAL.—The term 'payment system' means a system used by a person described in subparagraph (B) to effect a credit

transaction, electronic fund transfer, or money transmitting service that may be used in connection with, or to facilitate, a restricted transaction, and includes—

''(i) a credit card system;

''(ii) an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service; and

''(iii) any other system that is centrally managed and is primarily engaged in the transmission and settlement of credit transactions, electronic fund transfers, or money transmitting services.

''(B) PERSONS DESCRIBED.—A person referred to in subparagraph (A) is—

''(i) a creditor;

''(ii) a credit card issuer;

''(iii) a financial institution;

''(iv) an operator of a terminal at which an electronic fund transfer may be initiated;

''(v) a money transmitting business; or

''(vi) a participant in an international, national, regional, or local network used to effect a credit transaction, electronic fund transfer, or money transmitting service.

''(3) RESTRICTED TRANSACTION.—The term 'restricted transaction' means a transaction or transmittal, on behalf of an individual who places an unlawful drug importation request to any person engaged in the operation of an unregistered foreign pharmacy, of—

''(A) credit, or the proceeds of credit, extended to or on behalf of the individual for the purpose of the unlawful drug importation request (including credit extended through the use of a credit card);

''(B) an electronic fund transfer or funds transmitted by or through a money transmitting business, or the proceeds of an electronic fund transfer or money transmitting service, from or on behalf of the individual for the purpose of the unlawful drug importation request;

''(C) a check, draft, or similar instrument which is drawn by or on behalf of the individual for the purpose of the unlawful drug importation request and is drawn on or payable at or through any financial institution; or

''(D) the proceeds of any other form of financial transaction (identified by the Board by regulation) that involves a financial institution as a payor or financial intermediary on behalf of or for the benefit of the individual for the purpose of the unlawful drug importation request.

''(4) UNLAWFUL DRUG IMPORTATION REQUEST.—The term 'unlawful drug importation request' means the request, or transmittal of a request, made to an unregistered foreign pharmacy for a prescription drug by mail (including a private carrier), facsimile, phone, or electronic mail, or by a means that involves the use, in whole or in part, of the Internet.

''(5) UNREGISTERED FOREIGN PHARMACY.—The term 'unregistered foreign pharmacy' means a person in a country other than the United States that is not a registered exporter under section 804.

''(6) OTHER DEFINITIONS.—

''(A) CREDIT; CREDITOR; CREDIT CARD.—The terms 'credit', 'creditor', and 'credit card' have the meanings given the terms in section 103 of the Truth in Lending Act (15 U.S.C. 1602).

''(B) ACCESS DEVICE; ELECTRONIC FUND TRANSFER.—The terms 'access device' and 'electronic fund transfer'—

''(i) have the meaning given the term in section 903 of the Electronic Fund Transfer Act (15 U.S.C. 1693a); and

''(ii) the term 'electronic fund transfer' also includes any fund transfer covered under Article 4A of the Uniform Commercial Code, as in effect in any State.

''(C) FINANCIAL INSTITUTION.—The term 'financial institution'—

''(i) has the meaning given the term in section 903 of the Electronic Transfer Fund Act (15 U.S.C. 1693a); and

''(ii) includes a financial institution (as defined in section 509 of the Gramm-Leach-Bliley Act (15 U.S.C. 6809)).

''(D) MONEY TRANSMITTING BUSINESS; MONEY TRANSMITTING SERVICE.—The terms 'money transmitting business' and 'money transmitting service' have the meaning given the terms in section 5330(d) of title 31, United States Code.

''(E) BOARD.—The term 'Board' means the Board of Governors of the Federal Reserve System.

''(7) POLICIES AND PROCEDURES REQUIRED TO PREVENT RESTRICTED TRANSACTIONS.—

''(A) REGULATIONS.—The Board shall promulgate regulations requiring—

''(i) an operator of a credit card system;

''(ii) an operator of an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service;

''(iii) an operator of any other payment system that is centrally managed and is primarily engaged in the transmission and settlement of credit transactions, electronic transfers or money transmitting services where at least one party to the transaction or transfer is an individual; and

''(iv) any other person described in paragraph (2)(B) and specified by the Board in such regulations,

to establish policies and procedures that are reasonably designed to prevent the introduction of a restricted transaction into a payment system or the completion of a restricted transaction using a payment system

''(B) REQUIREMENTS FOR POLICIES AND PROCEDURES.—In promulgating regulations under subparagraph (A), the Board shall—

''(i) identify types of policies and procedures, including nonexclusive examples, that shall be considered to be reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; and

''(ii) to the extent practicable, permit any payment system, or person described in paragraph (2)(B), as applicable, to choose among alternative means of preventing the introduction or completion of restricted transactions.

''(C) NO LIABILITY FOR BLOCKING OR REFUSING TO HONOR RESTRICTED TRANSACTION.—

''(i) IN GENERAL.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, and any participant in such payment system that prevents or otherwise refuses to honor transactions in an effort to implement the policies and procedures required under this subsection or to otherwise comply with this subsection shall not be liable to any party for such action.

''(ii) COMPLIANCE.—A person described in paragraph (2)(B) meets the requirements of this subsection if the person relies on and complies with the policies and procedures of a payment system of which the person is a member or in which the person is a participant, and such policies and procedures of the payment system comply with the requirements of the regulations promulgated under subparagraph (A).

''(D) ENFORCEMENT.—

''(i) IN GENERAL.—This subsection, and the regulations promulgated under this subsection, shall be enforced exclusively by the Federal functional regulators and the Federal Trade Commission under applicable law in the manner provided in section 505(a) of the Gramm-Leach-Bliley Act (15 U.S.C. 6805(a)).

''(ii) FACTORS TO BE CONSIDERED.—In considering any enforcement action under this subsection against a payment system or person described in paragraph (2)(B), the Federal functional regulators and the Federal Trade Commission shall consider the following factors:

''(I) The extent to which the payment system or person knowingly permits restricted transactions.

''(II) The history of the payment system or person in connection with permitting restricted transactions.

''(III) The extent to which the payment system or person has established and is maintaining policies and procedures in compliance with regulations prescribed under this subsection.

''(8) TRANSACTIONS PERMITTED.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, is authorized to engage in transactions with foreign pharmacies in connection with investigating violations or potential violations of any rule or requirement adopted by the payment system or person in connection with complying with paragraph (7). A payment system, or such a person, and its agents and employees shall not be found to be in violation of, or liable under, any Federal, State or other law by virtue of engaging in any such transaction.

''(9) RELATION TO STATE LAWS.—No requirement, prohibition, or liability may be imposed on a payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, under the laws of any state with respect to any payment transaction by an individual because the payment transaction involves a payment to a foreign pharmacy.

''(10) TIMING OF REQUIREMENTS.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, must adopt policies and procedures reasonably designed to comply with any regulations required under paragraph (7) within 60 days after such regulations are issued in final form.

''(11) COMPLIANCE.—A payment system, and any person described in paragraph (2)(B), shall not be deemed to be in violation of paragraph (1)—

''(A)(i) if an alleged violation of paragraph (1) occurs prior to the mandatory compliance date of the regulations issued under paragraph (7); and

''(ii) such entity has adopted or relied on policies and procedures that are reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; or

''(B)(i) if an alleged violation of paragraph (1) occurs after the mandatory compliance date of such regulations; and

''(ii) such entity is in compliance with such regulations.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the day that is 90 days after the date of enactment of this Act.

(c) IMPLEMENTATION.—The Board of Governors of the Federal Reserve System shall promulgate regulations as required by subsection (h)(7) of section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333), as added by subsection (a), not later than 90 days after the date of enactment of this Act.

SEC. 10009. IMPORTATION EXEMPTION UNDER CONTROLLED SUBSTANCES IMPORT AND EXPORT ACT.

Section 1006(a)(2) of the Controlled Substances Import and Export Act (21 U.S.C. 956(a)(2)) is amended by striking ''not import the controlled substance into the United States in an amount that exceeds 50 dosage

units of the controlled substance.'' and inserting ''import into the United States not more than 10 dosage units combined of all such controlled substances.''.

SEC. 10010. SEVERABILITY.

If any provision of this title, an amendment by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments made by this title, and the application of the provisions of such to any person or circumstance shall not affected thereby.

SEC. 10011. CERTIFICATION.

(a) IN GENERAL.—This title (other than this section), and the amendments made by this title, shall become effective only if the Secretary of Health and Human Services certifies to Congress that the implementation of this title, and the amendments made by this title, will—

(1) pose no additional risk to the public's health and safety; and

(2) result in a significant reduction in the cost of covered products to the American consumer.

(b) EFFECTIVE DATE.—Notwithstanding any other provision of this title, or of any amendment made by this title—

(1) any reference in this title, or in such amendments, to the date of enactment of this title shall be deemed to be a reference to the date of the certification under subsection (a); and

(2) each reference to ''January 1, 2012'' in section 10006(c) shall be substituted with ''90 days after the effective date of this title''.

SA 3157. Mrs. SHAHEEN (for herself, and Mr. MERKLEY) 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. IMPROVEMENTS TO COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.

Section 1181 of the Social Security Act (as added by section 6301) is amended—

(1) in subsection (d)(2)(B)—

(A) in clause (ii)(IV)—

(i) by inserting '', as described in subparagraph (A)(ii),'' after ''original research''; and

(ii) by inserting '', as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate'' after ''publication''; and

(B) by amending clause (iv) to read as follows:

''(iv) SUBSEQUENT USE OF THE DATA.—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.'';

(2) in subsection (d)(8)(A)(iv), by striking ''not be construed as mandates for'' and inserting ''do not include''; and

(3) in subsection (f)(1)(C), by amending clause (ii) to read as follows:

''(ii) 5 members representing physicians and providers, including 3 members representing physicians (at least 1 of whom is a surgeon), 1 of whom is either a nurse or a State-licensed integrative health care practitioner, and 1 of whom is a representative of a hospital.''.

SA 3158. 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:

At the end, insert the following:

TITLE __—PROVIDING TAX EQUITY

Subtitle A—Use of Health Savings Accounts for Non-Group High Deductible Health Plan Premiums

SEC. __001. USE OF HEALTH SAVINGS ACCOUNTS FOR NON-GROUP HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following new clause:

''(v) a high deductible health plan, other than a group health plan (as defined in section 5000(b)(1)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

Subtitle B—Medical Care Access Protection

SEC. __101. SHORT TITLE.

This subtitle may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. __103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any

person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. __104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. __105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that

party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. __106. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. __107. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __108. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. __110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act

establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section __105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3159. 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:

At the end, insert the following:

TITLE K__—HSA CONTRIBUTION LIMIT

Subtitle A—Increase in HSA Contribution Limit

SEC. __001. INCREASE IN LIMIT FOR HSA CONTRIBUTIONS TO EQUAL MAXIMUM HIGH DEDUCTIBLE HEALTH PLAN OUT-OF-POCKET LIMIT.

(a) IN GENERAL.—Section 223(b)(2) of the Internal Revenue Code of 1986 (relating to exceptions) is amended—

(1) by striking ''$2,250'' in subparagraph (A) and inserting ''the dollar amount specified under subsection (c)(2)(A)(ii)(I) for such taxable year'', and

(2) by striking ''$4,500'' in subparagraph (B) and inserting ''the dollar amount specified under subsection (c)(2)(A)(ii)(II) for such taxable year''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to months beginning after the date of the enactment of this Act.

Subtitle B—Medical Care Access Protection

SEC. __101. SHORT TITLE.

This subtitle may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. __103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of

society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. __104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. __105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting

for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. __106. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. __107. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __108. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. __110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law

under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section __105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3160. Mr. BEGICH 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 subtitle C of title IV, insert the following:

SEC. 4208. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

(a) ESTABLISHMENT.—There is established a task force to be known as the ''Interagency Access to Health Care in Alaska Task Force'' (referred to in this section as the ''Task Force'').

(b) DUTIES.—The Task Force shall—

(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and

(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.

(c) MEMBERSHIP.—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:

(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

(A) The Department of Health and Human Services.

(B) The Centers for Medicare and Medicaid Services.

(C) The Indian Health Service.

(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

(A) The Department of Veterans Affairs.

(B) The Veterans Health Administration.

(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).

(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).

SA 3161. 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 101, between lines 19 and 20, insert the following:

(3) INCLUSION OF HIGH DEDUCTIBLE HEALTH PLANS IN CERTAIN STATES.—

(A) IN GENERAL.—If a State is described in subparagraph (B) with respect to health plans offered in the individual or small group market, then, on and after the certification date—

(i) a health plan described in subparagraph (C) shall be treated as a qualified health plan under this section, and as minimum essential coverage under section 5000A of such Code, for purposes of this Act and the amendments made by this Act; and

(ii) no requirement imposed by any provision of, or any amendment made by, this Act shall apply with respect to such plan or issuer thereof.

(B) STATE DESCRIBED.—For purposes of this paragraph—

(i) IN GENERAL.—A State is described in this subparagraph with respect to the individual or small group market within the State if the applicable State authority determines for any calendar year after 2013 that the percentage increase in average annual premiums for health insurance coverage in such market for the calendar year over the preceding calendar year exceeds the percentage increase for such period in the Consumer Price Index for all urban consumers published by the Department of Labor.

(ii) CERTIFICATION DATE.—The term ''certification date'' means the first date on which the applicable State authority certifies a determination described in clause (i).

(iii) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' has the meaning given such term by section 2791(d)(1) of the Public Health Service Act.

(C) HIGH DEDUCTIBLE HEALTH PLAN.—A health plan is described in this subparagraph if the plan is a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that meets all requirements under such section to be offered in connection with a health savings account.

SA 3162. Mr. SPECTER (for himself and 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 1925, between lines 14 and 15, insert the following:

Subtitle C—Provisions Relating to the Safety of Drugs and Biological Products

SEC. 7201. ENSURING THE SAFETY OF DRUGS AND BIOLOGICAL PRODUCTS CONTAINING BLOOD, BLOOD COMPONENTS, AND BLOOD DERIVATIVES.

Section 351 of the Public Health Service Act (42 U.S.C. 262), as amended by section 7002, is further amended by adding at the end the following:

''(m) BLOOD, BLOOD COMPONENTS, AND BLOOD DERIVATIVES.—

''(1) REGULATION AND LICENSURE.—The Secretary shall issue regulations that—

''(A) require a person seeking approval of any drug or licensure of a biological product that contains blood, blood components, or blood derivatives to—

''(i) submit an application for licensure pursuant to this section; and

''(ii) demonstrate the clinical safety, purity, and potency of such drug or product; and

''(B) provide analytical methods and standards to evaluate the quality of the blood, blood components, or blood derivatives contained in the new drug or biological product throughout the manufacturing process.

''(2) BIOLOGICAL PRODUCTS AND DRUG PRODUCTS CONTAINING BLOOD, BLOOD COMPONENTS, OR BLOOD DERIVATIVES.—A drug or biological product described in paragraph (1) that contains blood, blood components, or blood derivatives shall include any drug or biological product that includes an active or inactive ingredient that—

''(A) contains blood, blood components, or blood derivatives and has the potential to—

''(i) transmit infectious agents, such as of a prion or a microbial origin; or

''(ii) cause an adverse immune reaction due to the presence of blood, blood components, or blood derivatives; and

''(B) is—

''(i) essential to the manufacture of the drug or product;

''(ii) determinate of the absorption and distribution of the drug or product when administered; and

''(iii) essential to the safety and efficacy of the drug or product.

''(3) OTHER PRODUCTS CONTAINING BLOOD, BLOOD PRODUCTS, OR BLOOD DERIVATIVES.—In addition to the drugs and biological products that meet the criteria described in paragraph (2), the Secretary may issue regulations to include other products containing blood, blood products, or blood derivatives as biological products subject to paragraph (1).

''(4) CONSISTENCY OF DEFINITIONS.—Notwithstanding any other provision of this Act or the Federal Food, Drug, and Cosmetic Act, after the date of enactment of the Patient Protection and Affordable Care Act, a drug or biological product that has been approved under section 505 of the Federal Food, Drug, and Cosmetic Act and that meets the criteria described in paragraph (2) shall be treated by the Secretary as a biological product approved under a biologics license application under this section.''.

SA 3163. 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 869, between lines 14 and 15, insert the following:

SEC. 3143. REVISION TO PAYMENT FOR CONSULTATION CODES.

(a) TEMPORARY DELAY OF ELIMINATION OF PAYMENT FOR CONSULTATION CODES.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to January 1, 2011, implement any provision contained in a final rule that eliminates or discontinues payment for consultation codes under the physician fee schedule and part B of title XVIII of the Social Security Act.

(b) EVALUATION PERIOD.—During the period prior to January 1, 2011, the Secretary of Health and Human Services shall consult with the Current Procedural Terminology Editorial Panel of the American Medical Association for the purpose of developing proposals to—

(1) modify existing consultation codes or establish new consultation codes to more accurately reflect the value provided through such consultation services; and

(2) minimize coding errors.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs, Subcommittee on Housing, Transportation, and Community Development, be authorized to meet during the session on the Senate on December 10, 2009 at 9:30 a.m., to conduct a hearing entitled ''Examining the Federal Role in Overseeing the Safety of Public Transportation Systems.''

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on December 10, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

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 10, 2009, at 9:30 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 10, 2009, at 10 a.m.

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

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet during the session of the Senate on December 10, 2009.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 10, 2009, at 10 a.m.

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

COMMITTEE ON THE JUDICIARY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 10, 2009, at 10 a.m., in SD–226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

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

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Disaster Recovery of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 10, 2009, at 2:30 p.m. to conduct a hearing entitled, ''Children and Disasters: A Progress Report on Addressing Needs.''

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 10, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON AVIATION OPERATIONS, SAFETY, AND SECURITY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on Aviation Operations, Safety, and Security of the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 10, 2009, at 10 a.m. in room 253 of the Russell Senate Office Building.

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

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that the following staff of the Finance Committee be permitted the privileges of the floor during debate on the health care bill: Angela Franklin, Kaitlin Guarascio, and Scott Allen.

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

EXTENSION OF AUTHORITY OF THE SECRETARY OF THE ARMY

Mr. DURBIN. Mr. President, I ask unanimous consent to proceed to the immediate consideration of H.R. 4165, which was received from the House.

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

The bill clerk read as follows:

A bill (H.R. 4165) to extend through December 31, 2010, the authority of the Secretary of the Army to accept and expend funds contributed by non-Federal public entities to expedite the processing of permits.

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

Mr. DURBIN. I ask unanimous consent that the bill be read three times and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the bill be printed in the RECORD.

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

The bill (H.R. 4165) was ordered to a third reading, was read the third time, and passed.

EXTENDING AIRPORT AND AIRWAY TRUST FUND AUTHORITY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4217, which was received from the House.

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

The bill clerk read as follows:

A bill (H.R. 4217) to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement programs, and for other purposes.

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

Mr. DURBIN. I ask unanimous consent that the bill be read three times and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the bill be printed in the RECORD.

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

The bill (H.R. 4217) was ordered to a third reading, was read the third time, and passed.

NO SOCIAL SECURITY BENEFITS FOR PRISONERS ACT OF 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4218, which was received from the House and is at the desk.

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

The bill clerk read as follows:

A bill (H.R. 4218) 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.

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

Mr. BAUCUS. Mr. President, I urge the Senate to pass by unanimous consent the ''No Social Security Benefits for Prisoners Act of 2009,'' which was recently passed by the House of Representatives.

This bill would prevent retroactive Social Security and Supplemental Security Income benefit payments from being issued to individuals while they are in prison, or in violation of conditions of parole or probation, or are fleeing to avoid prosecution for a felony or a crime punishable by sentence of more than one year.

Under current law, the Social Security Act already prohibits payment of current monthly benefits to such individuals. This bill ensures this prohibition applies to retroactive benefit payments as well. The bill allows any payments that are withheld to be paid once the person is no longer in prison, or in violation of conditions of parole or probation, or are fleeing to avoid prosecution.

This bill makes a common sense reform to the Social Security Act and I urge my colleagues to support the bill.

I thank my colleagues for their support.

Mr. DURBIN. I ask unanimous consent that the bill be read three times and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and any statements relating to the matter be printed in the RECORD.

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

The bill (H.R. 4218) was ordered to a third reading, was read the third time, and passed.

ORDERS FOR FRIDAY, DECEMBER 11, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Friday, December 11; that follow 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 proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each, with Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes.

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

PROGRAM

Mr. DURBIN. Mr. President, the majority leader came to the floor this evening and asked for permission to move to four pending amendments on the health care bill and it was not given. The Republican leader objected. We are hoping to renew that unanimous consent request tomorrow so we can wrap up the Omnibus appropriations bill and move quickly back to debate on the health care bill. I am hoping we can do that, in the interests of moving through some of the important amendments now pending.

We expect two votes tomorrow on motions to waive points of order with respect to the consolidated appropriations conference report. Those votes should require 60 affirmative votes. Senators will be notified when votes are scheduled. Senators should also be prepared for votes Saturday morning.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. If there is no further business to come before the Senate, I ask unanimous consent it adjourn under the previous order.

There being no objection, the Senate, at 8:04 p.m., adjourned until Friday, December 11, 2009, at 10 a.m.